APPENDIX A

IN THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

Nos. 95-1965, 95-2140

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN and COMPCARE HEALTH SERVICES INSURANCE CORPORATION,
Plaintiffs-Appellees, Cross-Appellants,

v.

MARSHFIELD CLINIC and SECURITY HEALTH PLAN OF WISCONSIN, INC.,
Defendants-Appellees. Cross-Appellees.

Appeals from the United States District Court
for the Western District of Wisconsin
No. 94 C 137 S—JOHN C. SHABAZ, *Judge*

ARGUED AUGUST 9, 1995—DECIDED SEPTEMBER 18, 1995

Before POSNER, *Chief Judge,* and BAUER and KANNE, *Circuit Judges.*

POSNER, *Chief Judge.* Blue Cross & Blue Shield United of Wisconsin ("Blue Cross" for short), and its subsidiary, Compcare Health Services Insurance Corporation, a health maintenance organization (HMO), brought suit last year

under sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2 against the Marshfield Clinic and its HMO subsidiary, Security Health Plan of Wisconsin, Inc. After a two-week trial, the jury brought in a verdict for both plaintiffs that, after remittitur, trebling, and addition of attorneys' fees, produced a judgment just short of $20 million to which the judge then added a sweeping injunction that we have stayed pending the decision of the defendants' appeal, which we have heard on an expedited schedule. (The plaintiffs filed a cross-appeal, but it was dismissed by agreement of the parties.) The speed with which this complex case was brought to trial is as commendable as it is unusual.

The two plaintiffs have distinct though overlapping claims. Compcare, Blue Cross's HMO, claims that the Marshfield Clinic—a nonprofit corporation owned by the 400 physicians whom it employs—has a monopoly which it acquired and has maintained by improper practices that have excluded Compcare from the HMO "market" in the counties of north central Wisconsin in which the Marshfield Clinic and its HMO subsidiary (Security) operate. This is a section 2 monopolization charge. Blue Cross claims that Marshfield, partly through its own monopoly power and partly by collusion with other providers of medical services, charged supracompetitive prices to patients insured by Blue Cross. This is a section 2 monopolization charge combined with a section 1 price-fixing and division-of-markets charge.

Although Marshfield is a town of only 20,000 people in a largely rural region, the Marshfield Clinic is the fifth largest physician-owned clinic in North America, with annual revenues in excess of $200 million. The Clinic has its main office in Marshfield but it has 21 branch offices scattered throughout the 14 counties of north central Wisconsin. Oddly, we cannot find in the record, nor were counsel able to inform us at argument, what percentage the 400 physicians employed by the Clinic comprise of all

the physicians in the 14 counties. We do know that the Clinic employs all the physicians in Marshfield itself and in several other towns—but one of these towns has only one physician—and all the physicians in one entire county—but a county that has only 12 physicians. Security, the Marshfield Clinic's HMO subsidiary, serves its subscribers through the physicians employed by the Clinic plus almost 900 other physicians with whom Security has contracts. These contracts are not exclusive—the physicians are free to work for other HMOs as well as to practice fee-for-service medicine—and in fact work for Security generates only 6 percent of these physicians' total income. In nine of the 14 counties in the north central region, Security has more than 90 percent of all subscribers to HMOs.

Compcare persuaded the jury that HMOs constitute a separate market, much as banks are a separate market from currency exchanges; and if there is a reasonable basis for this finding in the evidence, we are bound to accept it regardless of what we might think as an original matter. But we have searched the record in vain for evidence that under contemporary principles of antitrust law would justify such a finding. An HMO is not a distinctive organizational form or assemblage of skills, as is plain from the fact that the physicians retained by Security, whether they are employees of the Marshfield Clinic or completely independent, to serve its subscribers serve other patients on a fee-for-service basis. An HMO is basically a method of pricing medical services. Instead of having the patient pay separately for each medical procedure, the patient pays a fixed annual fee for all the services he needs and the HMO undertakes to provide those services with the physicians with whom it has contracts. The different method of pricing used by the HMO has, of course, consequences both for the practice of medicine and for the allocation of the risk of medical expenses. The method of pricing gives the HMO an incentive to minimize the procedures that it performs, since the marginal

revenue it derives from each procedure is zero. Hence HMOs are thought to reduce "waste" and to encourage preventive care, although those hostile to the HMO concept believe that the principal effect is merely to reduce the amount of medical care that patients receive. The risk-shifting feature of the concept lies in the fact that if a subscriber incurs above-average medical expenses, the excess cost is borne by the HMO rather than by the subscriber (or by his insurer, or more likely by both because of copayment and deductible provisions in the insurance policy), while if he incurs below-average medical expense the difference enures to the benefit of the HMO rather than to him or his insurer (or, again, both). To control the upside risk that it incurs, the HMO provides medical services through physicians with whom it has contracts specifying their compensation, rather than merely reimbursing some percentage of whatever fee they might happen to charge for their services. This means that the HMO must be able to line up enough physicians with whom to contract to provide its subscribers with a more or less complete menu of medical services. Compcare complains that Security's contracts with physicians require them to refer their patients to the Clinic rather than to "independent" physicians. But that is of the essence of an HMO: the subscriber must take the service offered by the physicians whom the HMO has enlisted.

Compcare's principal argument is that Security has enlisted such a large fraction of the physicians in the 14-county north central region that Compcare cannot find enough "independent" physicians to be able to offer HMO services competitive with Security's—hence Security's huge market shares in 9 of the 14 counties. Supposing this is true—as seems unlikely since Security's almost 900 independent physicians are available to join other HMOs, along with an unknown number of physicians neither employed by the Marshfield Clinic nor retained by Security—it has monopolistic significance only if HMOs constitute a market separate from other contractual forms in which

many of the same physicians sell their services. Of this we cannot find any evidence.

In defining a market, one must consider substitution both by buyers and by sellers, IIA Phillip E. Areeda, John L. Solow & Herbert Hovenkamp, *Antitrust Law: An Analysis of Antitrust Principles and Their Application* ¶ 530a (1995), and let us start with buyers. The record shows, what is anyway well known, that individuals, and their employers, and medical insurers (the real "buyers" of medical services, according to the plaintiffs) regard HMOs as competitive not only with each other but also with the various types of fee-for-service provider, including "preferred provider" plans (generally referred to as "PPOs," for "preferred provider organization") under which the insurer offers more generous reimbursement if the insured patronizes physicians who have contracts with the insurer to provide service at low cost to its insureds. HMOs, though they have made great strides in recent years because of the widespread concern with skyrocketing medical costs, remain relative upstarts in the market for physician services. Many people don't like them because of the restriction on the patient's choice of doctors or because they fear that HMOs skimp on service since, as we said, the marginal revenue of a medical procedure to an HMO is zero. From a short-term financial standpoint—which we do not suggest is the only standpoint that an HMO is likely to have—the HMO's incentive is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible. HMOs compensate for these perceived drawbacks by charging a lower price than fee-for-service plans.

We do not wish to associate ourselves with the critics of HMOs. All that is important to our consideration of this appeal is that many people believe—whether rightly or wrongly is of no moment—that HMOs are not an unalloyed blessing; and this means that the price that an

HMO can charge is constrained not only by competition from other HMOs but also by competition from forms of medical-services contracting that are free from the perceived perverse incentive effects of the HMO form. As far as we know or the record shows, even in areas where there is only one HMO most of the people in its service area do not subscribe to it even if its prices are lower than those of fee-for-service providers.

We do not understand Compcare to be contending that insurance companies cannot find enough physicians in the north central region willing to sign contracts with them to staff preferred-provider plans. This has a dual significance. Such plans are particularly close substitutes for HMOs, since they use the insurer's clout with physicians to drive down price. And if, as the record shows, they are feasible even in areas supposedly dominated by the Marshfield Clinic, and even without including any physicians employed by the Clinic, it is impossible to understand what barrier there could be to the formation of HMOs. All that is needed is an array of physicians who among them provide a broad range of medical services, and the same thing is needed for a preferred-provider plan. Ability to create a preferred-provider plan therefore implies ability to create an HMO, and so implies in turn that if Security raised its prices above competitive levels, and if people had a strong preference for HMOs over preferred-provider plans despite the similarities between the two systems for providing medical care, the operators of those plans would convert them to HMOs. If so, those plans are part of the same market with HMOs. So Blue Cross and Blue Shield of Indiana argued in *Ball Memorial Hospital, Inc. v. Mutual Hospital Ins., Inc.*, 784 F.2d 1325 (7th Cir. 1986), and we accepted its argument. *Id.* at 1331-37.

As we said earlier, the definition of a market depends on substitutability on the supply side as well as on the demand side. Even if two products are completely differ-

ent from the consumer's standpoint, if they are made by the same producers an increase in the price of one that is not cost-justified will induce producers to shift production from the other product to this one in order to increase their profits by selling at a supracompetitive price. *SBC Communications Inc. v. FCC*, 56 F.3d 1484, 1493-94 (D.C. Cir. 1995); cf. *Ball Memorial Hospital, Inc. v. Mutual Hospital Ins., Inc., supra*, 784 F.2d at 1335. The services offered by HMOs and by various fee-for-service plans are both provided by the same physicians, who can easily shift from one type of service to another if a change in relative prices makes one type more lucrative than others.

We thus do not believe that a reasonable jury, confronting the record compiled in the district court, could find that HMOs constitute a separate market. Nor, if we examine a more plausible market such as all physician services in north central Wisconsin and thus shift our focus from Compcare, the HMO, to the Marshfield Clinic itself, is there any basis in the record for treating the Clinic not as the alliance of 400 physicians that is the Marshfield Clinic but instead as the almost 1300 physicians who are either employed by the Clinic or have contracts with Security. The 900 independent contractors derive only a small fraction of their income from those contracts, as we have seen, and the contracts do not forbid them to join other HMOs or otherwise compete with Security or with the Marshfield Clinic.

It is true that because of the sparsity of the physician population in north central Wisconsin the physicians employed by the Clinic have a large share of the market for physician services, since, for primary care anyway (an important qualification—people will go a long way for a liver transplant), that market is a local one. Remember, there is one entire county in which all the physicians are employed by the Clinic. We do not understand Compcare to be arguing that *this* is the market that the Clinic monopolized; the damages to Compcare from being

excluded (if it was excluded—we do not know) from that tiny market would be tiny. Compcare paints with a broader brush, drawing a dizzying series of concentric circles around the Clinic's offices and counting the physicians who can serve people living in the circles. It would have been much simpler and we suppose just as good—having in mind the desirability of avoiding a hunt for the snark of delusive exactness—to have treated the counties as the markets. But whatever the precise method chosen, Compcare is unable to show that in what it chooses to regard as the relevant geographic market or series of linked geographic markets for physician services the Marshfield Clinic employed 50 percent or more of the physicians serving the market. And 50 percent is below any accepted benchmark for inferring monopoly power from market share, *United States v. Rockford Memorial Corp.*, 898 F.2d 1278, 1285 (7th Cir. 1990); *Fineman v. Armstrong World Industries, Inc.*, 980 F.2d 171, 201-02 (3d Cir. 1992); *Colorado Interstate Gas Co. v. Natural Gas Pipeline Co.*, 885 F.2d 683, 694 n. 18 (10th Cir. 1989); *United States v. Aluminum Co. of America*, 148 F.2d 416, 424 (2d Cir. 1945) (L. Hand, J.), and the Clinic has given us no reason for lowering the mark. Compcare is able to derive larger shares only by defining submarkets of specific, very narrowly defined medical procedures, called "Diagnostic Related Groups," such as circumcision of a male 17 years old or older, circumcision of a male under 17, hysterectomy, and reconstructive surgery for the uterine system, in a few of which (14 out of 494, according to Compcare's expert witness) the physicians employed by or under contract with Marshfield Clinic performed most of the procedures in north central Wisconsin. As the examples we have given show, classification in a DRG is unrelated to the conditions of supply. Many, no doubt most, physicians perform or are capable of performing more than one procedure, and are therefore part of the market even if at present not active in it. If the Clinic overprices a particular procedure, other phy-

sicians capable of performing that procedure will have an added incentive to do so, knocking down the excessive price.

Compcare also asked the jury to infer monopoly power directly from the Clinic's high prices, and high rate of return, relative to the prices and rates of return of its competitors. But when dealing with a heterogeneous product or service, such as the full range of medical care, a reasonable finder of fact cannot infer monopoly power just from higher prices—the difference may reflect a higher quality more costly to provide—and it is always treacherous to try to infer monopoly power from a high rate of return. Taking the second point first, not only do measured rates of return reflect accounting conventions more than they do real profits (or losses), as an economist would understand these terms, Susan Rose-Ackerman, "Unfair Competition and Corporate Income Taxation, 34 *Stan. L. Rev.* 1017, 1025 n. 28, 1031 n. 43 (1982); Michael Boudin, "Forensic Economics," 97 *Harv. L. Rev.* 835, 837 (1984), but there is not even a good economic theory that associates monopoly power with a high rate of return. Firms compete to become and to remain monopolists, and the process of competition erodes their profits. Conversely, competitive firms may be highly profitable merely by virtue of having low costs as a result of superior efficiency, yet not sufficiently lower costs than all other competitors to enable the firm to take over its market and become a monopolist. As for high prices, one of the complaints against HMOs, remember, is that they skimp on service. One HMO may charge higher prices than other HMOs (and Security does charge higher prices) not because it has a monopoly but because it is offering better service than the other HMOs in its market. Compcare itself stresses the quality of the Marshfield Clinic's doctors, as part of its argument that it cannot succeed unless the Clinic is forced to join it. Generally you must pay more for higher quality.

So Security is not a monopolist of HMO services, because HMOs are not a market; and the Marshfield Clinic, its parent, is not a monopolist either because it does not control its independent contractors and once they are excluded, the Clinic (which is to say the physicians who own and are employed by it—who are the firm, functionally speaking) does not have a monopoly of physician services in the north central region or in any parts of the region other than parts too small to support more than a handful of physicians. If the Marshfield Clinic is a monopolist in any of these areas it is what is called a "natural monopolist," which is to say a firm that has no competitors simply because the market is too small to support more than a single firm. If an entire county has only 12 physicians, one can hardly expect or want them to set up in competition with each other. We live in the age of technology and specialization in medical services. Physicians practice in groups, in alliances, in networks, utilizing expensive equipment and support. Twelve physicians competing in a county would be competing to provide horse-and-buggy medicine. Only as part of a large and sophisticated medical enterprise such as the Marshfield Clinic can they practice modern medicine in rural Wisconsin.

We are mindful that a concept of essential or bottleneck facilities has been used from time to time to require a natural monopolist to cooperate with would-be competitors. E.g., *Otter Tail Power Co. v. United States,* 410 U.S. 366 (1973); *MCI Communications Corp. v. AT&T Corp.,* 708 F.2d 1081, 1132-33 (7th Cir. 1983). The principal case remains the old St. Louis terminal case. *United States v. Terminal Railroad Ass'n,* 224 U.S. 383 (1912). A consortium of 14 of the 24 railroads that shipped freight across the Mississippi River at St. Louis got control of the terminal facilities at each side of the river. The Supreme Court, while assuming that the operation of these facilities as a single entity was the most efficient way to operate them (that is, they comprised a

natural monopoly), held that the Sherman Act required the consortium to provide access to the terminal facilities to the 10 other railroads on nondiscriminatory terms. The decision, along with the rest of the decisions in the essential-facilities line, has been criticized as having nothing to do with the purposes of antitrust law. E.g., Herbert Hovenkamp, *Federal Antitrust Policy: The Law of Competition and Its Practice* § 7.7 (1994); Phillip Areeda, "Essential Facilities: An Epithet in Need of Limiting Principles," 58 *Antitrust L.J.* 841 (1990); Scott D. Makar, "The Essential Facilities Doctrine and the Health Care Industry," 21 *Fla. St. U.L. Rev.* 913 (1994). Had the terminal facilities been owned by a firm unaffiliated with any railroad, the firm could have charged whatever prices it wanted, including prices that discriminated against some of the users (monopolists frequently price discriminate), because the antitrust laws do not regulate the prices of natural monopolists. A natural monopolist that acquired and maintained its monopoly without excluding competitors by improper means is not guilty of "monopolizing" in violation of the Sherman Act, *National Reporting Co. v. Alderson Reporting Co.*, 763 F.2d 1020, 1023-24 (8th Cir. 1985); *United States v. Aluminum Co. of America, supra,* 148 F.2d at 430, and can therefore charge any price that it wants, *Ball Memorial Hospital, Inc. v. Mutual Hospital Ins., Inc., supra,* 784 F.2d at 1339; *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 296-98 (2d Cir. 1979), for the antitrust laws are not a price-control statute or a public-utility or common-carrier rate-regulation statute.

And the charging of a high price is, so far as potential competitors are concerned, an attracting rather than an excluding practice. Consumers are not better off if the natural monopolist is forced to share some of his profits with potential competitors, as required by *Terminal Railroad Ass'n.* Similarly, if the practice of medicine in some sparsely populated county of north central Wisconsin is a natural monopoly, consumers will not be helped by our

forcing the handful of physicians there to affiliate with multiple HMOs. Those physicians will still charge fees reflecting their monopoly.

We are not authorized to abrogate doctrines that have been endorsed and not yet rejected by the Supreme Court —as we acknowledged, indeed emphasized, with specific reference to the "essential facilities" doctrine, in *Olympia Equipment Leasing Co. v. Western Union Telegraph Co.*, 797 F.2d 370, 376 (7th Cir. 1986)—but we do not understand Compcare to be trying to pin the tail on the natural-monopoly donkey. Its argument is not that the Marshfield Clinic "owns" some tiny natural monopolies scattered throughout its market area, to which it must admit Compcare, but that the Clinic itself is an essential facility that any HMO may demand access to on equal terms, like the excluded railroads in the terminal case. To be an essential facility, however, a facility must be essential. The terminal association controlled 100 percent of a market, assumed to be properly defined, consisting of terminal services at St. Louis. The Clinic does not control 100 percent—or even 50 percent—of any properly defined market. It did have a monopoly market share of the HMO "market," but we have held that that is not a proper market; and likewise the DRGs. Nor can the Clinic's market share be levered up to 100 percent by the argument that the Clinic's reputation is so superb that no one will sign up with an HMO or preferred-provider plan that does not have the Clinic on its roster. The suggestion that the price of being "best" is to be brought under the regulatory aegis of antitrust law and stripped of your power to decide whom to do business with does not identify an interest that the antitrust laws protect. "The successful competitor, having been urged to compete, must not be turned upon when he wins." *United States v. Aluminum Co. of America, supra,* 148 F.2d at 430.

Since monopoly power was not proved, we need not evaluate the practices by which the Clinic acquired or

maintained it. But we will not conceal our skepticism that they are exclusionary in an invidious sense. Compcare argues that the Clinic refused to allow its employees to "cross-cover" with "independent" physicians, in the sense of physicians not employed by or affiliated by contract with the Clinic (that is, agree to care for another physician's patients when that physician is on vacation or otherwise unavailable in exchange for a reciprocal agreement by the other physician), discouraged hospitals that its staff controlled from joining HMOs that compete with Security, and restricted staff privileges at those hospitals of "independent" physicians. All these practices are ambiguous from the standpoint of competition and efficiency. Hospitals are not public utilities, required to grant staff privileges to anyone with a medical license. The Marshfield Clinic's reputation for high quality implies selectivity in the granting of staff privileges at hospitals affiliated with the Clinic. Physicians employed by the Clinic, which has its own HMO, are hardly to be expected to steer their patients to another HMO, as they would be doing if they used their control of hospital staffs to induce the hospital to join another HMO. And given the extensive network constituted by the physicians either employed by or contracting with the Clinic, they would have little occasion to "cross-cover" with other physicians and would be reluctant to do so if, as is completely consistent with Compcare's version of the "essential facilities" doctrine, the Clinic maintains a reputation for high quality by being selective about the physicians to whom it entrusts its customers. But the important point is that, even if these practices are as we doubt tortious interferences with Compcare's business, they do not constitute monopolizing in violation of section 2 of the Sherman Act in the absence of acceptable proof, here lacking, of monopoly power.

We turn to Blue Cross's case. Blue Cross claims that it was overcharged by the Clinic. Many of the individuals whom Blue Cross insures in north central Wisconsin are

customers of the Marshfield Clinic, paying for the services they receive from the Clinic on a fee-for-service basis. (The Clinic's doctors devote only a small part of their time to Security's HMO clientele.) Blue Cross pays the Clinic directly the portion of the fee that Blue Cross has agreed with its insureds to cover. The Clinic seeks to head off Blue Cross's claim at the pass, arguing that since the Clinic's fee-for-service contracts are with the patients themselves—it has no contract with Blue Cross—only the patients have "standing" (a term here not used in the jurisdictional sense, *Associated General Contractors of California, Inc. v. California State Council of Carpenters*, 459 U.S. 519, 535 n. 31 (1983)) to complain about the alleged overcharging.

If the patients paid the entire fees to the Clinic and then were reimbursed in whole or part by Blue Cross, the Clinic would be right: only the patients could sue. The Supreme Court has been emphatic that only the direct purchaser from an allegedly overcharging defendant has standing to maintain an antitrust suit. *Kansas v. Utilicorp United Inc.*, 497 U.S. 199 (1990); *Illinois Brick Co. v. Illinois*, 431 U.S. 720 (1977). But here the money went directly from Blue Cross to the Clinic, and although the two entities were not linked by any overarching contract, each payment and acceptance was a separate completed contract. We do not think more is required to establish Blue Cross's right to sue to collect these overcharges. *Pennsylvania Dental Ass'n v. Medical Service Ass'n*, 815 F.2d 270, 276-77 (3d Cir. 1987); *Todorov v. DCH Healthcare Authority*, 921 F.2d 1438, 1455 (11th Cir. 1991); cf. *Kartell v. Blue Shield of Mass., Inc.*, 749 F.2d 922, 926 (1st Cir. 1984). It would be cumbersome, to say the least, for patients of the Marshfield Clinic to organize into a class action to recover money that the patients never paid and that if they received in a judgment or settlement they would have to share with Blue Cross; for Blue Cross could seek and probably obtain restitution of moneys paid by mistake to the insureds

because paid for expenses that the insureds had not in the end incurred. 2 George E. Palmer, *The Law of Restitution* § 11.2(d), p. 491 (1978); *Home Ins. Co. v. Honaker*, 480 A.2d 652 (Del. 1984); *Ticor Title Ins. Co. v. Graham*, 576 N.E.2d 1332, 1336-37 (Ind. App. 1991).

Against this it can be argued that if Blue Cross reimburses an insured for say 80 percent of a $100 charge that should have been only $50, Blue Cross has lost $40 but the insured has lost $10 and so there is still a basis for a class action. Still, in this example anyway it is Blue Cross that bears the lion's share of the loss, as well as being able to proceed on its own without the aggregation of separate plaintiffs required for a class action; and the class action would enable a full recovery of the damages inflicted by the defendant only if the class members received a tremendous windfall—only, that is, if the class is allowed to recover $40 rather than $10 (and the entire $50 will of course be trebled). It can further be argued that the insured might pay the whole $50, because Blue Cross would reduce the percentage that it reimburses in order to shift the cost of the monopolist's overcharge to the hapless insureds. But the insureds may not be hapless—may in fact be members of the employees' group insurance plan of a large employer with plenty of insurance options. We need not pursue these issues. Blue Cross paid Marshfield Clinic directly, in accordance with Blue Cross's contractual obligations to its insureds, and if it paid too much because the Clinic violated the antitrust laws then it ought to be allowed to sue to recover these damages.

We note a tension between Blue Cross's claim and Compcare's. Blue Cross claims that the Clinic overcharged. The higher its prices, the greater the opening for competitors, such as Compcare. Even if Compcare could not get a foot-hold in the HMO "market," it could, of course, provide medical services through other means,

such as a preferred-provider plan; and the higher the prices charged by the Marshfield Clinic, the more attractive such a plan offered by Compcare would be to employers and other purchasers of medical plans. To put the point differently, Blue Cross has a dual role in this case, as a buyer of medical services from Marshfield Clinic and, through its Compcare subsidiary, as a competitor of the Clinic. As a competitor its interest is in the Clinic's charging high prices, but as a buyer its interest is in the Clinic's charging low prices. Damages to Compcare are windfalls to Blue Cross, and vice versa. The damages awarded by the jury to the two plaintiffs (since they are economically one entity) should have been netted against each other rather than aggregated.

But that is a detail, since Compcare, for the reasons discussed earlier, was not entitled to recover any damages at all. Forget Compcare, then, and think of Blue Cross solely as a purchaser of medical services. Insofar as it paid high prices because the Marshfield Clinic was a monopolist, its claim must fail because the Clinic was not shown to be an illegal monopolist; a lawful monopolist can charge what it wants. But Blue Cross also claims that the Clinic colluded with competitors to raise prices above competitive levels. That claim is independent of the Clinic's being a monopolist.

Two forms of collusion are charged, with various furbelows and arabasques that can be ignored. The first is collusion between the Clinic and its affiliated (as distinct from employed) physicians. Here the tension between the two plaintiffs' cases again comes to the surface, since it will be recalled that Compcare in its case treats the affiliated physicians as a part of the Clinic, and a firm cannot collude with itself. Forget all that; the only evidence of collusion is that the Clinic, when buying services from the affiliated physicians either directly or through Security, would not pay them more than what these physicians charge their other patients. This is said

to set a floor underneath these physicians' prices, since if they cut prices to their other patients their reimbursement from the Clinic will decline automatically. This is an ingenious but perverse argument. "Most favored nations" clauses are standard devices by which buyers try to bargain for low prices, by getting the seller to agree to treat them as favorably as any of their other customers. The Clinic did this to minimize the cost of these physicians to it, and that is the sort of conduct that the antitrust laws seek to encourage. It is not price-fixing. *Brook Group Ltd. v. Brown & Williamson Tobacco Corp.*, 113 S. Ct. 2578, 2589-90 (1993); *Hospital Corp. of America v. FTC*, 807 F.2d 1381, 1392 (7th Cir. 1986); *Ball Memorial Hospital, Inc. v. Mutual Hospital Ins., Inc., supra*, 784 F.2d at 1338.

The other form of collusion alleged is more troublesome. The Clinic is said to have agreed with some of its competitors, in particular the North Central Health Protection Plan, an HMO that had 37,000 subscribers, to divide markets, a practice that violates section 1 of the Sherman Act. *Palmer v. BRG of Georgia, Inc.*, 498 U.S. 46 (1990) (per curiam). The analogy between price-fixing and division of markets is compelling. It would be a strange interpretation of antitrust law that forbade competitors to agree on what price to charge, thus eliminating price competition among them, but allowed them to divide markets, thus eliminating all competition among them.

The charge of a division of markets in this case is backed up by some pretty strong documents. In one of them an executive of the Marshfield Clinic, after noting that "at the time in which management of Marshfield Clinic and North Central Health Protection Plan established the Free Flow arrangements, the parties involved purposely chose not to place in writing clear descriptions of their respective Plan service areas so as to minimize any risk in terms of violation of antitrust laws," remarks

that some years ago physicians affiliated with the NCHPP "wished to establish a practice in Marshfield and we took the position that the Free Flow agreement did not support that activity"—and they backed off. The implications of this only slightly Aesopian wording are backed up by statistics showing that Security had fewer than 30 percent of the HMO subscribers in the two counties in which NCHPP was active, while in the counties surrounding those two counties on three sides it had more than 90 percent of the HMO subscribers.

We think the evidence of a division of markets, though a little scanty, was sufficient to sustain the jury's verdict on this (and only this) aspect of the case—provided this is not one of those cases in which a division of markets or other cartel-like activity is actually essential to the provision of a lawful service. *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979); *National Collegiate Athletic Ass'n v. Board of Regents*, 468 U.S. 85 (1984); *General Leaseways, Inc. v. National Truck Leasing Ass'n*, 744 F.2d 588 (7th Cir. 1984). The "Free Flow" agreement to which the document from which we quoted refers was an agreement whereby Security's physicians and NCHPP's physicians could refer patients to each other without getting the permission of their superiors. The plan of the physician who rendered the service would bill the other plan for its cost. This was no doubt a valuable service, expanding the range of physicians to whom people enrolled in these two HMOs could turn. But the Clinic has failed to explain why, to provide this service, it was necessary for the two plans to agree not to open offices in each other's territories. We can imagine an argument that would run as follows: if NCHPP, say, opened an office in Marshfield, the doctors staffing that office would constantly be referring patients to the Clinic because it has such a plethora of doctors in Marshfield (remember that it employs *all* the doctors working in that town). The office would be running a referral business, "free riding" on the reputation and

quality of Marshfield's doctors, and perhaps it would be difficult to devise a reimbursement plan under which these doctors would be compensated for these services. It is not a bad argument, but it is not made by the Clinic and it has no support in the record.

We conclude that the jury verdict on liability must stand insofar as the charge of a division of markets is concerned, and therefore the provisions of the injunction (IV(A)(3), (B)(3), (C)(3), (D)(3), and (E)(2), and V(D)(1)—and possibly others; but for the sake of clarity and completeness the injunction ought to be rewritten from scratch in light of our invalidating most of it) that forbid the Clinic to divide markets with competing plans or groups. The rest of the injunction falls with the charges that we have held to be without legal or factual basis. No part of the award of damages or of costs and attorneys' fees can stand, because these items were not segregated by offense. There must be a new trial limited to damages for dividing markets. The burden will be on Blue Cross to show how much less it would have paid the Clinic had the Clinic refrained from that illegal practice.

We have not discussed every contention of the parties, but have said enough to indicate the basis for our decision. As a detail, we urge the bench and bar of this circuit not to imitate the special verdict on liability that went to the jury in this case. The verdict form contained 18 questions. If the jury wanted to find for the plaintiff on every contested point, all it had to do (and all it did do) was write "yes" 18 times. A verdict so configured, like a plea colloquy in which the answer that the defendant is expected to give to every one of the judge's questions is "yes" *Castillo v. United States*, 34 F.3d 443, 445 (7th Cir. 1994), invites rote answers rather than the careful consideration of the structure of the plaintiff's case that the use of a special verdict is intended to foster. Cf. *W.T. Rogers Co. v. Keene*, 778 F.2d 334, 346 (7th Cir. 1985). None of the purposes ascribed to the giving of a special

verdict, *Stewart & Stevenson Services, Inc. v. Pickard,* 749 F.2d 635, 644 (11th Cir. 1984); 9A Charles Alan Wright & Arthur R. Miller, *Federal Practice and Procedure* § 2508 (1995), of which probably the most important is to minimize the likelihood or scope of a retrial in a case in which there is more than one independent ground for recovery, are served by a verdict form that does not invite the jurors to use their heads. Given the broad discretion of the trial judge in the formulation of special verdicts, e.g., *Hibma v. Odegaard,* 769 F.2d 1147, 1157 (7th Cir. 1985), and the fact that no objection was made to the form employed here, we do not suggest that this form would have constituted reversible error if the point had been argued; we merely offer for what it is worth our belief that it is not the best possible form, because it does not force the jurors to think before filling it out.

The judgment is affirmed in part, reversed in part, and remanded for further proceedings consistent with this opinion. Costs on appeal to the appellants.

AFFIRMED IN PART,
REVERSED IN PART, AND REMANDED.

A true Copy:

Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

APPENDIX B

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF WISCONSIN

94-C-137-S

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN and COMPCARE HEALTH SERVICES INSURANCE CORPORATION,

Plaintiffs,

v.

THE MARSHFIELD CLINIC and SECURITY HEALTH PLAN OF WISCONSIN, INC.,

Defendants.

MEMORANDUM

Plaintiffs Blue Cross & Blue Shield United of Wisconsin ("Blue Cross") and Compcare Health Service Insurance Corporation ("Compcare") commenced an antitrust action against defendants Marshfield Clinic ("Marshfield") and Security Health Plan of Wisconsin, Inc. ("Security") for money damages, injunctive and declaratory relief. The case was tried to a jury which found for plaintiffs on each question of the Special Verdict finding that (1) plaintiffs established one or more primary care, pediatric care, specialty care and HMO services relevant product and geographical markets and (2) monopoly power therein, (3) defendants engaged in anti-competitive conduct to obtain monopoly power, (4) defendants attempted and (5) conspired to obtain monopoly power, (6) defendants entered into a contract, combination, or conspiracy to unreasonably restrain trade, and (7) defendants allocated customers, territories, product or service markets and fixed fees or prices. The jury found damages in the amount of $10.5 million in favor of Blue Cross and $5,669,227 in favor of Compcare against the defendants. The Court trebled the damages and entered judgment. The action is before this Court on defendants' motion for judgment as

a matter of law pursuant to Rule 50 of the Federal Rules of Civil Procedure and/or a new trial pursuant to Rule 59 on both the liability and damage verdicts and on plaintiffs' motion for injunctive and declaratory relief.

RULE 50 MOTION

When addressing defendants' motion for judgment as a matter of law the Court must determine whether the evidence presented combined with all reasonable inferences that may be drawn from it, is sufficient to support the verdict when viewed in the light most favorable to the party winning the verdict. Any conflicts in the evidence must be resolved in favor of the party winning the verdict, and every permissible inference favoring that party must be drawn. *Tennes v. Massachusetts Dept. of Revenue,* 944 F.2d 372, 377 (7th Cir.1991).

The Court does not evaluate the credibility of witnesses, nor otherwise weigh the evidence nor consider the numerous post trial affidavits submitted by the parties and those other evidentiary responses which plaintiffs oppose in objecting to defendants' motion for leave to file a sur-reply. Further, when entering its order concerning defendants' motion for judgment as a matter of law or new trial the Court does not consider the numerous petitions, letters, editorials, articles and communications addressed to it which may be better suited for consideration by a legislative body or member thereof. Had both sides expended their energies before trial as they did after trial they might have received a satisfactory verdict. As determined on the Friday before trial, all evidence shall be presented at trial. Once concluded and a verdict entered no further evidence will be considered. The Court's examination of the trial record and motions relating thereto is the basis for its decisions on the motions it will now address.

The jury had sufficient evidence including the testimony of plaintiffs' expert Warren Greenberg to find that plaintiffs had established one or more of the following relevant product and geographical markets: primary care, pediatric

care and one or more specialty care markets. Greenberg specifically defined 13 product markets concerning primary care, pediatrics, specialty care and their geographical limitations. The jury could have readily determined that in nine relevant product and geographical markets Marshfield had a market share in excess of 60% for three years 1991 to 1993. His testimony was supplemented with statistical and economic tests according to Elzinger Hogarty. Although he had not studied a separate HMO economic market for trial or in his prior work, having failed to conclude that there is an HMO services market separate from other forms of health care financing—such as PPOs, POS and regular indemnity insurance, the jury could have also determined that he did not reject the probability thereof.

There is a further legally sufficient evidentiary basis for a reasonable jury to find that plaintiffs established a relevant product and geographical market in HMO services. The Court acknowledges the importance of finding an HMO market. Without an HMO market, plaintiff Compcare's claim for exclusion from the market cannot stand. Plaintiff's late attempts to argue an alternative basis for liability are to no avail.

The jury had before it the testimony of Michael E. Bernstein from which it could reasonably find from the experiences which he brought that there is a specific HMO Market. (Tr. at 83.) He cited federal law for qualified HMOs which employers are required to provide where they have more than 25 employees and that HMOs compete with one another for such considerations.

Vicki Thoreson, sales director for Blue Cross/Blue Shield for the North Central region testified she sold products other than HMOs and that Security HMO does not compete with these products. From her testimony the jury could find that plaintiffs' PPO plan is a totally different type product than the Security HMO and that customers perceive a fee for service plan as different from an HMO which has different pricing and characteristics.

Jeffrey J. Nohl, president of Compcare which sells HMO products, specifically described those features from

which the jury could reasonably find that an HMO is other than traditional indemnity insurance. Nohl stressed the managed care aspects of an HMO as a separate product. Based upon his ten years of experience in the HMO market he testified as an expert that an HMO is not a financial mechanism as is indemnity insurance. He referred also to separate federal and state laws and regulations relating to the HMO as well as those regulations which separate surplus and capital. The State of Wisconsin has a program for state employees which provides HMO health care for which HMOs may compete. Although Nohl admittedly is not that expert who commands a fee in excess of $400,000.00, nevertheless he testified to three distinct characteristics.

The jury was advised of three distinct characteristics to include, first, the gate keeper where a patient chooses a primary care doctor. The second feature provides for controls on use, monitored care a with capitation agreement and the third provides for preventive care and wellness programs where the quality of care is chosen as a part of HMO membership. Michael L. Glassman, the defendants' expert opined that an HMO market did not exist but rather a health care financing market existed of which the HMO is a part. He did not believe the Wisconsin program which requires or mandates separate HMOs to state employees and Medicaid recipients was relevant nor was the separate capital structure for companies who are able to sell HMOs. He had not considered the separate regulations and laws relating to the HMO believing them not to have made a difference in his opinion. From all of this the jury could have reasonably determined that an HMO is a distinct and unique form of health care financing for which a relevant product market exists.

Some limited interchangeability exists in the health care financing market particularly between HMOs and PPOs and between HMOs and indemnity insurance when a monopoly raises the cost of HMOs. Richard A. Posner in *Antitrust Law, An Economic Perspective,* 127-128

(1976) explained how monopoly prices can make poor substitutes appear interchangeable to the consumer. "In the leading case of *United States v. E.I. du Point de Nemours & Co.* (the cellophane monopolization case), the Supreme Court stated that the 'market is composed of products that have reasonable interchangeability for the purposes for which they are produced-price, use and qualities considered.' " *Id.* at 127. The cellophane formulation is deficient in that it

> fails to specify the price level at which the products alleged to comprise the relevant market are reasonably interchangeable. . . . At a high enough price even poor substitutes look good to the consumer. . . . In *du Pont* the issue was whether the defendants had monopoly power, and in that setting it was vital to specify whether cellophane and other flexible wrapping material were reasonably interchangeable at the *current* price of cellophane which might be a monopoly price, or at the *competitive* price (i.e., cost) of cellophane. Reasonable interchangeability at the current price but not at a competitive price level, far form demonstrating absence of monopoly power, might well be a symptom of that power; this elementary point was completely overlooked by the Court.

Id. at 127-128. Thus, HMOs may be interchangeable with indemnity insurance when they are priced at monopolistic levels, as is Security HMO, but are considerably less expensive than indemnity insurance, and correspondingly less substitutable, in competitive markets. Considering this and the consumer's convenience and preference, the jury had legally sufficient evidence upon which it could find that the consumer expects to receive a unique and distinctive service from an HMO not either envisioned or provided by indemnity insurance, all at a lower cost.

Finally, Nohl testified to a geographical market which was described as a 20 to 30 minute drive time around

those primary care doctors who are "the key since each person is to select one and all care is channeled through that primary care doctor. With that selection you have a relationship with the primary care doctor. A 20 to 30 minute drive around is basically the area that an HMO can operate."

The Court is well aware of the defendants' position relating to the HMO Market and has examined among others the following cases: *Ball Memorial Hosp., Inc. v. Mutual Hosp. Insurance Inc.*, 784 F.2d 1325, 1334-1336 (7th Cir. 1986); *Tunis Brothers Co., v. Ford Motor Co.*, 952 F.2d 715 (3d Cir. 1991); *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589 (1st Cir. 1993) as well as *Morgenstern v. Wilson*, 29 F.3d 1291 (8th Cir. 1994).

The Court then concludes that this is not the case referred to in *Morgenstern* described as "when an expert opinion is not supported by sufficient facts to validate it in the eyes of the law, or when indisputable record facts contradict or otherwise render the opinion unreasonable, it cannot support a jury's verdict." *Id.* at 1297

Here there was not that evidence that the HMO services failed to occupy a relevant product and geographical market, only the argument from Glassman that plaintiffs had not provided enough such evidence and that he had not considered those criteria which were utilized.

The Court further notes that the plaintiffs' expert witness on damages, John Beyer, testified that Compcare was foreclosed from the core areas of Marshfield Clinic's service area from selling Compcare HMO Products and his opinion considering HMOs as a separate market is stated as follows: "If you mean by separate market defining it as a separate relevant product market in an antitrust setting as we heard in the prior phase of this trial, the answer is no." (Tr. at 2583.) His testimony specifically related however to two distinct primary markets. The Greater Marshfield Health Plan which operates in the counties of Wood, Jackson, Clark, western part of

Marathon, Taylor, Rusk and to a certain extent Sawyer and the Northcare Plan in the counties of Oneida, Vilas, Iron, Ashland and part of Lincoln where Security has 100% enrollment in five of the above counties. (Exhibit 934, attached)

Similarly, plaintiff Compcare's essential facility claim is supported by the evidence. A monopolist's refusal to deal is governed by the "essential facilities doctrine." *MCI Communications Co. v. AT&T Co.*, 708 F.2d 1081, 1132 (7th Cir. 1983).

> "Such a refusal may be unlawful because a monopolist's control of an essential facility can extend monopoly power from one stage of production to another, and from one market into another. Thus, the antitrust laws have imposed on firms controlling an essential facility the obligation to make the facility available on non-discriminatory terms.
>
> The case law sets forth four elements necessary to establish liability under the essential facilities doctrine: (1) control of the essential facility by a monopolist; (2) a competitor's inability practically or reasonably to duplicate the essential facility; (3) the denial of the use of the facility to a competitor; and (4) the feasibility of providing the facility.

Id. at 1132-1133. To be essential, a " 'facility need not be indispensable; it is sufficient if duplication of the facility would be economically infeasible and if denial of its use inflicts a severe handicap on potential market entrants.' " *Fishman v. Estate of Wirtz*, 807 F.2d 520, 539 (7th Cir. 1986) (citations omitted.), *accord, MCI*, 708 F.2d at 1148.

Defendants challenge Compcare's essential facility claim by stating that the Marshfield doctors are not an essential facility because Nohl testified that POS plans are in the HMO product market and plaintiffs have established a POS plan in areas surrounding Marshfield. That plaintiff established a small POS plan in surrounding

areas does not change the fact that the jury could reasonably find that Compcare could not establish a competing HMO in Marshfield. Moreover, there was evidence that Blue Cross could not duplicate the network of doctors. It was difficult to recruit rural doctors. (Tr. at 540.) Obtaining new doctors or contracting with existing doctors was handicapped by Marshfield's monopolistic tactics, (Tr. at 480), and Marshfield's control of hospital privileges. (Tr. 358-363, 399-401.) Defendants' business justifications for refusing to deal with plaintiffs are refuted by evidence of Marshfield's blanket policy of not entering contracts with other HMOs. (Exhibit 1426.) It was for the jury to decide if Marshfield offered its facility on reasonable grounds. A reasonable jury could have found it was feasible for Marshfield to offer its doctors to Compcare to form an HMO because Marshfield made physicians available to Security and NCHPP, (Tr. at 983-984), and other clinics have contracts with multiple HMOs. (Tr. at 1770.)

Plaintiffs also provided sufficient evidence from which a reasonable jury could have found that plaintiffs suffered antitrust injury. Defendants claim that Blue Cross did not prove it suffered antitrust injury because Blue Cross did not produce evidence that it paid a supra-competitive price, rather Blue Cross only presented evidence that it paid higher than average prices. Defendants claim that higher than average prices are not necessarily the same as supra-competitive prices because of factors like quality and investment. Defendants, however, are wrong. There was sufficient evidence from which a reasonable jury could find Blue Cross paid a supra-competitive price. Blue Cross paid charges to Marshfield that were 10% above the UCR. (Tr. at 127.) In a market basket study, the City of Marshfield's charges were the highest of 23 cities in the state. (Tr. at 160-170.) This was sufficient for the jury to infer the charges were supra-competitive. Antitrust injury may be proved by inference or circumstantial evidence. *Zenith Radio Co. v. Hazeltine Research, Inc.*, 395 U.S. 100, 125 (1969). Moreover supra-competitive prices

are prices that are higher than those Blue Cross would have paid in the absence of defendants' anti-competitive conduct and plaintiffs produced this type of evidence.

Similarly, Blue Cross has standing as a purchaser of physician services. This issue has been resolved in this Court's Order Denying Defendants' Motion for Summary Judgment.

Plaintiffs also produced sufficient evidence defining the other relevant markets. The relevant market must be ascertained in order to determine whether other sellers exist whose competition may limit defendants' monopoly power. *United States v. Grinnell Co.*, 384 U.S. 563, 571 (1966) A relevant geographic market is "the set of sellers to which a set of buyers can turn for supplies at existing or slightly higher prices." *A.A. Poultry Farms, Inc. v. Rose Acre Farms, Inc.*, 881 F.2d 1396, 1403 (7th Cir. 1989). In a case involving health care, the relevant market must reflect actual patient and physician practices. *SmithKline Co. v. Eli Lilly & Co.*, 427 F. Supp. 1089, 1117-18 (E.D. Pa. 1976), *aff'd*, 575 F.2d 1056 (3rd Cir. 1978), *cert. denied*, 439 U.S. 838 (1978). Delineation of the relevant market is for the trier of fact. *Fishman v. Wirtz*, 807 F.2d 520, 531 (7th Cir. 1986).

Defendants first challenge the sufficiency of the geographic definition of the market for specialty care, claiming that the geographic market for specialty care includes Minnesota and plaintiffs' expert, Greenberg, erred in leaving it out. Defendants cite to *Morgenstern v. Wilson*, 29 F.3d 1291 (8th Cir. 1994) for support. Greenberg did consider Minnesota, (Tr. at 813), but did not include it in the market. He explained that certain communities on the edge of a market can be in two relevant markets. (Tr. at 815.) The jury was entitled to accept this explanation. Plaintiffs distinguish *Morgenstern*, which found the jury's definition of the relevant market to be in error because it left out a city only 50 miles from the defendants' location, because Minnesota providers are close to the state border, but far from Marshfield. Duluth, the Twin Cities, and

Rochester are 217, 166-200 & 160 miles away from Marshfield.

Second, defendants challenge the geographic definition of the primary and pediatric care markets because they overlap and allegedly ignore competing sellers. Plaintiffs' expert, Greenberg, considered the relevant factors: the area defendants targeted, (Tr. at 734), used economic and statistical tests including Elzinger-Hogarty, (Tr. at 737), and economic literature which indicates a 30 mile radius for primary care. (Tr. at 737.) Greenberg explained to the jury how markets can overlap.(Tr. at 804-805.) The jury was entitled to embrace his opinion.

Third, defendants challenge the product market for specialty care asserting that there is no evidence that services in DRGs are good substitutes. Defendants claim that DRGs are merely hospital fee codes. A relevant product market is composed of products or services that are reasonably interchangeable for the purpose for which they are produced. *du Pont,* 351 U.S. at 404. DRGs are a system developed by health economists and used by the federal and state governments and insurance carriers. (Tr. at 730-731.) A jury could reasonably rely on this evidence.

Plaintiffs also provided sufficient evidence from which the jury could find that defendants possessed monopoly power. In some cases, a firm's share of the relevant market indicates market power because market share may reflect a firm's ability to reduce the total output in the market and so raise prices. *Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins.,* 784 F.2d 1325, 1336 (7th Cir. 1986). Part of proving market power is proving barriers to entry. Unless barriers to entry prevent rivals from entering the market at the same cost of production, even a very large market share does not establish market power. *Will v. Comprehensive Accounting Co.,* 776 F.2d 665, 672 (7th Cir. 1985). The lower the barriers to entry, and the shorter the lags of new entry, the less power existing firms have to raise prices. When the supply is highly

elastic, existing market share does not signify power. *Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins. Inc.*, 784 F.2d 1325, 1335 (7th Cir. 1986).

Defendants have not challenged the existence of monopoly power for HMO services.[1] Defendants do, however, challenge the jury's finding of monopoly power in other relevant markets. Defendants assert that no barriers to entry existed because a study demonstrated actual entry of new non-Marshfield doctors into the area. The jury could reasonably have disregarded this evidence because the study counted Marshfield-affiliated doctors as independent doctors, not as Marshfield doctors. (Tr. at 2165.) The study was also statistically flawed. (Tr. at 2291, 2293-2296.) There was ample evidence from which a reasonable jury could have found barriers to entry. It is customary in rural practice to provide cross-coverage. (Tr. at 553, 588.) Marshfield denied cross-coverage to competitors. (Tr. at 501, 526, 463, 353, 397, 480.) Without cross-coverage a doctor must hire temporary doctors known as *locum tenens*. (Tr. at 515-516, 2243-2244, 2267.) This is a significant cost that Marshfield does not incur and is not incurred in other parts of the state. Marshfield also denied and restricted the hospital staff privileges of competitors. (Tr. at 358-363, 399-407.) Lastly, plaintiffs' expert, Greenberg, testified that there were barriers to entry.

Defendants also challenge the inclusion of Marshfield affiliated doctors within defendants' percentage of the market share. Plaintiffs presented sufficient evidence that would justify a jury adding the number of affiliated doctors to defendants' market share. The affiliation contracts are renewable or may be terminated on an annual basis. (Ex. 1444.) The Clinic expects the affiliates to refer non-

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[1] The Court notes that defendants' market share in the primary care market in some areas exceeds defendants' market share in the HMO services market. However, this issue is resolved by the damages award because plaintiffs' expert, Dr. Beyer, calculated Compcare's exclusion damages only in those areas in which defendants had market power for HMOs, smaller areas than the primary care markets.

Security patients to Marshfield, (Tr. at 1030, 1721), and they do, (Tr. at 1030), in a greater volume than non-Security patients. (Ex. 1454, 1841, 1704.) Plaintiffs also presented evidence that price competition between the affiliates and Marshfield is controlled by Marshfield. Marshfield obtains the fee schedules of its affiliates and approves or disapproves them. (Tr. at 1021, 1023.) Marshfield has also allocated markets and territory with affiliated providers, Rhinelander Medical Center and Wausau Medical Center. (Tr. at 865-868, 870-871.) Lastly, plaintiffs' expert testified as to why affiliated providers are included in defendants' market share. (Tr. at 750-752.)

Similarly there was sufficient evidence from which a reasonable jury could find that defendants engaged in anti-competitive conduct. Anti-competitive conduct is defined as the willful acquisition or maintenance of monopoly power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident. *Aspen Skiing Co. v. Aspen Highlands Skiing Co.*, 472 U.S. 585, 596, n.19 (1984); *Olympia Equip. Leasing v. Western Union Telegraph*, 797 F.2d 370, 373 (7th Cir. 1986). In this context willful means conduct designed to maintain or enhance monopoly power improperly. *Olympia*, 797 F.2d at 373. A monopoly like any other competitor, "is permitted and indeed encouraged to compete aggressively on the merits." *Id.* at 375. Improper conduct is conduct characterized as "exclusionary", "anti-competitive" or "predatory". *Aspen Skiing Co. v. Aspen Highlands Skiing Co.*, 472 U.S. 585, 602. In determining whether conduct is exclusionary "it is relevant to consider its impact on consumers and whether it has impaired competition in an unnecessarily restrictive way." *Id.* at 605. If a firm has been "attempting to exclude rivals on some basis other than efficiency," it is fair to characterize its behavior as predatory. *Id.* It is also relevant to consider its impact on antitrust defendants and rivals. *Id.* "Thus, 'exclusionary' comprehends at the most behavior that not only (1) tends to impair the opportunities of rivals, but also (2) either does

not further competition on the merits or does so in an unnecessarily restrictive way." *Id.* at 605, n.32.

Defendants assert that there was no evidence of anti-competitive conduct because all defendants' actions have a legitimate business justification and lack anti-competitive intent. There is abundant evidence in the record from which a reasonable jury could find anti-competitive conduct. In the face of direct evidence that defendants acted with the specific intent to restrict competition, the jury was entitled to disregard defendants' alternative explanations. For example, clinics were acquired to threaten competitors. (Tr. at 531-533.) Security affiliation was used to threaten doctors and to force compliance with referral policies. (Tr. at 445-447.) Defendants warned potential new entrants that cross-coverage would be denied because they were competitors, (Tr. at 489), and hospital privileges were denied to competitors. (Tr. 360-363.) These actions excluded competitors from the market and resulted in supra-competitive prices for physician services and HMOs.

Plaintiffs' claim for attempted monopolization, however, must fail. First defendants allege that plaintiffs did not produce any evidence of intentional predatory conduct or dangerous probability of success. These challenges are meritless. However, defendants argue that the Special Verdict was inconsistent because Question 4 asked whether defendants attempted to monopolize in any relevant market in which they do *not* possess monopoly power. Defendants claim that given this finding there can be no finding of antitrust injury because the Court defined antitrust injury as paying supra-competitive prices and exclusion from competition and the definition of monopoly power is the power to control price or exclude competition. According to defendants, by definition defendants must possess market power in order to cause plaintiffs' antitrust injury.

The Special Verdict does contain an inconsistency. The jury found all the relevant markets to exist in Ques-

tion 1. In Question 2 the jury answered "yes" to the question, "Do the defendants possess monopoly power in any relevant market you found to exist?" In Question 4 the jury answered "yes" to "Have defendants attempted to monopolize in any relevant market in which they do not possess monopoly power?". The Court finds that the jury found monopoly power in all relevant markets. Plaintiffs in response to defendants' challenge do not list any markets in which defendants may not have possessed market power. Because defendants possessed monopoly power in all relevant markets asserted by plaintiffs, the answer to Question 4 cannot stand. The Court finds for defendants as a matter of law on Question 4, the attempt to monopolize claim.

Attempted monopolization customarily provides a cause of action when a plaintiff fails to prove monopoly power. A plaintiff may also attempt to monopolize in a market in which at first it does not possess monopoly power, but later succeeds in attaining monopoly power. Of course a defendant by definition attempts to do what it ultimately succeeds in doing, especially if the heightened intent requirement is met. Although plaintiffs meet the other requirements of a cause of action for attempted monopolization, given the wording of the question the cause of action for attempt in this instance must fail. This is of little significance because it does not affect the relief provided by the jury (damages) or by the court (equitable relief).

Defendants err in their contentions that plaintiffs did not suffer antitrust injury. Plaintiffs suffered antitrust injury for damages by paying supra-competitive prices and being excluded from the marketplace. Plaintiffs also suffered antitrust injury for injunctive relief because of the *threat* of continuing to pay supra-competitive prices and being excluded from the market in the future. Section 16 of the Clayton Act provides in part that "[a]ny person, firm, corporation, or association shall be entitled to sue for and have injunctive relief . . . against threatened loss or damage by a violation of the antitrust laws." Sections

4 (the damages antitrust injury statute) and 16 of the Clayton Act "are thus best understood as providing complementary remedies for a single set of injuries." *Cargill, Inc. v. Monfort of Co., Inc.*, 479 U.S. 104, 113 (1986). Sections 16 and 4 differ in certain ways. Section 4 requires a plaintiff to show actual injury, but section 16 only requires plaintiff to show "threatened" loss or damage. *Id.* Section 16 requires plaintiff to show a threatened injury for which it would be entitled to compensation if the injury actually occurred. *Id.* at 112. Consequently plaintiff must allege threatened antitrust injury damage or loss "of the type the antitrust laws were designed to prevent and that flows from that which makes defendants' acts unlawful." *Id.* at 113.

There was sufficient evidence from which the jury could find that defendants conspired to monopolize. Defendants claim that plaintiffs did not prove a conspiracy to monopolize because they failed to rebut defendants' evidence of business justification for its predatory conduct, because there was no antitrust injury, and because plaintiffs did not connect the conspiracy with a specific market or impact. However, plaintiffs did provide sufficient evidence from which a jury could find that defendants conspired to monopolize. There was evidence that defendants conspired to control the Rice Clinic through a management services contract, (Tr. at 1092-1093), and that defendants conspired with the Gunderson Clinic to monopolize HMO services. (Tr. 1093-1094.)

Plaintiffs have also provided sufficient evidence from which the jury could find violations of section 1 of the Sherman Act for questions 6, 7, and 8 of the Special Verdict. Question 6 of the Special Verdict asked the jury whether defendants "entered into a contract, combination or conspiracy the purpose of which or predictable effect was to unreasonably restrain trade in any relevant market." Question 7 asked whether defendants engaged in four specific actions which are per se violations of the Sherman Act, (1) allocating customers, (2) allocating territory, (3) allocating product or service mar-

kets, or (4) fixing fees or prices. Question 8 asked whether the purpose or predictable effect of these four actions was to unreasonably restrain trade. Question 6 was provided on the Special Verdict to include any section 1 violations that were not specifically enumerated as per se violations in Questions 7 as well as encompassing those violations specifically enumerated in Question 7. Question 7 lists the actions which this Court held to be per se violations of section 1 in its Memorandum and Order Denying Plaintiffs' Motion for Summary Judgment. Question 8 applied the Rule of Reason and Joint Venture analysis to the per se violations in compliance with the Seventh Circuit's direction that a Rule of Reason analysis also be applied to per se violations in case courts differ on whether violations deserve per se treatment or Rule of Reason treatment because of the uncertain state of the law. *See General Leaseways Inc. v. National Truck Leasing Ass'n.*, 744 F.2d 588, 596 (7th Cir. 1984).

There is sufficient evidence in the record of violations of section 1. For example, there was evidence that Marshfield allocated markets and territory with Rhinelander Medical Center, Wausau area physicians and NCHPP. (Tr. at 865-868, 870-871.) There was evidence that Marshfield allocated outpatient and urgent care services with the Ministry Corporation. (Tr. at 927-929.) There was evidence of price-fixing between Marshfield and its affiliated providers. The affiliated providers had only one fee schedule for both Security and non-Security patients, (Tr. at 887-889), and Marshfield approved or disapproved it. (Tr. at 887-889.) This is not a straight buyer-seller relationship, it is a relationship of competing sellers. Additional evidence suggested that although HMOs generally pay 20-40% less than list price for physician services, (Tr. at 2308), Marshfield Clinic approved those prices at 100% of list. (Tr. at 868-870.) This price fixing resulted in supra-competitive prices in the Marshfield area. (Tr. at 127, 169.) The overall effects of these practices were supra-competitive prices and elimination or reduction of competition. For ex-

ample, the agreement between Marshfield and Rhinelander Medical Center to sign up with only one HMO, Security, and to drop NCHPP reduced competition. (Tr. at 712-713.) The contract with Wausau Medical Center which states that it cannot contract with other HMOs reduced competition. (Tr. at 1361.)

Contrary to defendants' contentions, it was the duty of the jury to weigh the evidence and balance the anti and pro competitive effects of the agreements at issue. The jury was properly instructed on both the Rule of Reason analysis and joint venture analysis. The role of the Court in a Rule 50 motion is not to reweigh the evidence, *Dombeck v. Milwaukee Valve Co.*, 823 F. Supp. 1475, 1477-78 (W.D. Wis. 1993), but to search the record for evidence of detrimental effects on competition. As stated above such evidence exists.

RULE 59, NEW TRIAL

When addressing defendants' motion for a new trial pursuant to Rule 59 the Court must consider whether the verdict is against the weight of the evidence, damages are excessive or trial is not fair to the moving party. *Forrester v. White*, 846 F.2d 29 (7th Cir. 1988).

Defendants claim they are entitled to a new trial on various other grounds to include the Court's failure to exclude the testimony of Jeffrey Nohl as an expert, the declination to give a statute of limitations instruction, improper instructions on plaintiffs' tying claims and that plaintiffs' evidence did not support their claim for lost profits.

The tying instructions provided by the Court were appropriate and necessary based upon the evidence presented. The statute of limitations instruction was provided in the damage phase of the trial as requested. The Court has also determined that Jeffrey Nohl with his 10 years experience in the HMO market but without the credentials of academia, a Phi Beta Kappa key or a price

tag in excess of $400,000.00 was nonetheless recognized as a witness by Rule 702 of the Federal Rules of Civil Procedure. The jury considered his experience and common sense discussion of the HMO market and regardless of the fact that he had not examined *Tunis* and believed a Buick was a separate product market, his testimony assisted the jury notwithstanding the complexity of this case.

If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise. The standard instruction provided the jury with the necessary guidance for considering his testimony. Nohl's opinion was apparently accepted by the jury and as difficult as it may be for defendants to accept, the relevant product and geographical limits apparently were understood and found to exist. It was not error for Nohl to testify.

DAMAGES

Defendants are correct that the evidence does not support plaintiffs' claims for damages.

Dr. Christenson testified that Blue Cross paid Marshfield Clinic over the past 6 years in the range of 25 to 30 million dollars. He further testified that had the Marshfield Clinic charged the average fee of other physicians in the state of Wisconsin Blue Cross would have paid significantly less, "by approximately 35% of the total reimbursement to Marshfield." Magically, based upon plaintiffs' argument the jury determined that $10,500,000 would fairly and reasonably compensate plaintiff Blue Cross for any antitrust injury which it sustained on or after February 16, 1988 which is the direct result of defendants' conduct in violation of the antitrust laws. None of the Christenson testimony relates to any relevant

market found by the jury to exist, nor to any of the exhibits to which he referred.

More appropriately, Beyer addressed the overcharge fees in the context of the previously identified markets testifying that $813,222.00 would be attributed to the primary care market, $66,958.00 attributed to the pediatric market and $205,897.00 attributed to the specialty care market for a total of $1,085,897.00.

When compared to the offhand opinion of Christenson based upon no evidence in the record the $1,085,897.00 does not appear excessive. In contrast, the $10,500,000.00 is monstrously excessive. Dr. Beyer did attribute a portion of the overcharges, $491,014.00, to the ASO and Cost Plus contracts providing the jury an opportunity to select a lower damage figure of $594,833.00 which it did as shown by its response to Question 2 of the damage verdict. In any event Beyer declined to make those reductions stating, "In my judgment I thought that would be appropriate partly because it increased the number of and the amount of information that could be used or drawn upon for comparing the prices of physicians in these two different benchmark areas and also because, based on several sources of information, there was no reason to believe that there would be any significant differentiation by geographic area of these types of insurance, ASO and cost-plus throughout Wisconsin. There was no reason to exclude it and good reason to include it." (Tr. at 2595.)

The defendants' damage expert Mark Abernathy, however, did indeed provide those good reasons which the jury apparently accepted. "The ASO contract is a contract with an employer group simply to administer the claims for that particular employer group. And if the employer group wishes to cap his risk, then you can arrange for stop-loss insurance. The employer group bears the risk of loss. In an administrative service contract

(ASO), you're simply processing claims for patients having health care and charging the fee for processing those claims. It's my opinion that it would be inappropriate to include ASO and self-insured contracts to damages calculations to Blue Cross/Blue Shield simply because Blue Cross/Blue Shield passes the claims through to the employer, they don't bear the expense of the claim."

Initially a plaintiff in an antitrust action has the burden to prove the fact of the injury—that defendants' conduct was a material cause of some injury to plaintiff's business. Once plaintiffs have established the fact of injury the burden of proving the amount of damages is more relaxed. *Moore v. Boating Industry Assoc.*, 754 F.2d 698, 717 (7th Cir. 1985) *vacated on other grounds*, 474 U.S. 895 (1985). Once causation of damages in an antitrust case has been established the *amount* of damages may be determined by a "just and reasonable estimate." *MCI Communications, Co. v. AT&T*, 708 F.2d 1081, 1161 (7th Cir. 1983). Since the Supreme Court has allowed for some measure of uncertainty in the calculation of antitrust damages, strict proof of which damages have been caused by which acts has not been required. *Id.* The Seventh Circuit, however, went on to hold that a damage award must reflect only those losses directly attributable to unlawful competition. *Id.* at 1161. The court in *MCI* ordered a new trial on damages because the damage study relied on by the jury in its damage award did not subtract those damages attributable to lawful competition. Nor was the jury provided with a methodology to reduce the amount of damages by the amount of lawful conduct. The Court noted the distinction between proof of causation of damages and proof of an amount of damages and reasoned that courts have been consistent in requiring plaintiffs to prove in a reasonable manner the link between the injury suffered and the *illegal* practices of the defendant.

A remittitur is appropriate in the case at bar even in light of the lower burden on a plaintiff in an antitrust action to prove the *amount* of damages. The damage award is clearly excessive, totally monstrous, contrary to the evidence presented at trial and based on a figure lacking adequate foundation. The error in the damage award to *Blue Cross* is somewhat analogous to the error in the damage award in *MCI*. The damage award to *Blue Cross* lacks testimony relating to the relevant markets and those markets in which defendants had market power. Without this information there is no casual link between essential elements of the cause of action and the damage award. Defendants are liable only for those damages directly caused by their illegal conduct. They are not liable for a percentage of all payments made to them by Blue Cross. Such an amount could reflect payments that are not the result of defendants' illegal conduct. Testimony relating overcharges to the relevant markets and the markets in which defendants had monopoly power is necessary to prove that those are the damages caused by illegal conduct. Such a requirement is not too onerous because plaintiff presented testimony relating damages to the relevant markets via Dr. Beyer.

As precise as Dr. Beyer was in addressing the overcharge damages to which Blue Cross/Blue Shield was entitled he was somewhat speculative in his approach when assessing those damages to be provided to plaintiff Compcare as a result of the defendants' foreclosure of HMO services to plaintiffs. He testified that an amount of damage in the Greater Marshfield area would be somewhere between 3.1 to 4.9 million dollars. He justified the higher amount based upon that evidence which demonstrated a cost shifting by the defendants. Evidence was provided in the testimony of Dwight Ruff and those memos to which he referred that Marshfield had the desire to minimize profits in its HMO because of its public and regulative nature. Defendants were obviously and

admittedly in a position to set the capitation rate at any level in order to show profits in one entity or the other. Its actual numbers generally showed a large increase in the capitation rate in 1993 which skewed the profits from about 50/50 to substantially in the clinic's favor. The 1993 capitation rate increase was about $8.00 yet the amounts added by Beyer for the cost shift was only $2.00 and $4.00. This amount seems likely to be less than the actual cost shift. Furthermore, the approximately one million dollar projected annual profit, even with the cost shift, is less than 20% of the average annual profit which Marshfield was realizing from its HMO. Although Beyer's estimate of the amount of cost shift may be speculative it was necessarily so because the information which went into that shift is exclusively within Marshfield's knowledge and is difficult to discern from available records. In conclusion under all of the circumstances the amount of lost HMO profits testified to by Beyer and accepted by the jury cannot be judged unreasonable.

While speculative in part the computation of HMO lost profits generally addreses a conservative approach and does not produce an unreasonably high result. Granting a remittitur is necessary because the jury added to Compcare's lost profits of $5,056,277.00 the amount of over charge damages in the amount of $594,883.00 which should have been awarded to Blue Cross at Question 1. (Exhibit 10413, attached) Accordingly the amount as found by the jury, $5,669,277.00 shall be reduced by said amount.

"For years we have been saying, without much visible effect, that people who want damages have to prove them, using methodologies that need not be intellectually sophisticated but must not insult the intelligence. *Post hoc ergo propter hoc* will not do; nor the enduing of simplistic extrapolation and childish arithmetic with the appearance of authority by hiring a professor to mouth

damages theories that make a joke of the concept of expert knowledge." *Schiller & Schmidt, Inc. v. Nordisco Corp.*, 969 F.2d 410, 415-416 (7th Cir. 1992) (Citations omitted).

This Court has determined that the defendants are entitled to a new trial on damages because they are monstrously excessive based upon that legally sufficient evidence which the jury failed to consider.

Accordingly, a remittitur will be entered where defendants are granted a new trial subject to an award of $594,883.00 to plaintiff Blue Cross and Blue Shield United of Wisconsin and $5,074,394.00 to plaintiff Compcare Health Services Insurance Corporation, amounts to be trebled by the Court. In the event plaintiffs fail to accept the remittitur set forth herein on or before April 3, 1995, a new trial on damages will be scheduled.

EQUITABLE RELIEF

Plaintiffs have requested broad, far-reaching equitable relief. Defendants have responded by denying the need for any injunctive relief or for limited injunctive relief in the alternative.

Section 16 of the Clayton Act provides:

> Any person, firm, corporation, or association shall be entitled to sue for and have injunctive relief . . . against threatened loss or damage by a violation of the antitrust laws . . . when and under the same conditions and principles as injunctive relief against threatened conduct that will cause loss or damages is granted by courts of equity, under the rules governing such proceedings. . . .

It is plaintiffs' burden to prove they are entitled to injunctive relief. *Wilk v. American Medical Ass'n.*, 895 F.2d 352, 366-367. (7th Cir. 1990) To be entitled to equitable relief plaintiffs must demonstrate (1) antitrust in-

jury, (2) that no adequate remedy at law exists, and (3) that the balance of hardships favors the imposition of equitable relief. *Cargill, Inc. v. Monfort of Colorado, Inc.*, 479 U.S. 104, 114 (1986); *Wilk*, 895 F.2d at 370. Traditional principles of equity apply under section 16. *Id.* Equitable relief is discretionary and not automatically available to an injured plaintiff. *Id.* The sole function of an action for injunction is to forestall future violations. *U.S. v. Oregon State Medical Soc.*, 343 U.S. 326, 333 (1952). It is unrelated to punishment or reparation. *Id.* A threat of future violation or contemporary violation of a nature likely to continue or recur is necessary for injunctive relief. *Id.; Wilk*, 895 F.2d at 367. Section 16 should be construed and applied with the purpose of enforcing the antitrust laws and with the knowledge that the remedy it affords, like other equitable remedies is "flexible and capable of nice 'adjustment and reconciliation between the public interest and private needs as well as between competing private claims.' " *Zenith Radio Co. v. Hazeltine Research, Inc.*, 395 U.S. 100, 131 (1969).

Instead of considering those post trial affidavits and other related documents, the Court refers to the record as stated earlier for that relief which should be addressed. The following testimony of Glassman is a part of that evidence which a court of equity should consider when granting injunctive and declaratory relief.

> My 4th conclusion is that if Marshfield Clinic is forced to do business in the fashion desired by Blue Cross and Compcare that competition will be harmed and that the consumers of Central and North Central Wisconsin will be left worse off because of that.

The first requirement for injunctive relief, antitrust injury, clearly exists and has been previously addressed in this Memorandum, this Court's Memorandum and Order Denying Defendants' Motion for Summary Judgment, and in the Special Verdict. As for the second requirement,

that there be no adequate remedy at law because of a threat of future violations, plaintiffs have argued that defendants have not admitted any wrongdoing and in fact vehemently deny their actions in any way violate the antitrust laws. To be considered in this analysis are the bonafides of the expressed intent to comply with the antitrust laws, the effectiveness of the discontinuance of the violations of the law and in some cases the character of the past violations. *Wilk*, 895 F.2d at 367. The court in *Wilk* considered as a factor in support of an injunction the failure of the defendant AMA to ever acknowledge that its practice of discriminating against osteopaths was illegal. Here, the monetary relief has been found adequate to provide relief to plaintiffs for the pecuniary loss they have already sustained and will sustain. The reasoned and substantial award of damages is likely to motivate defendants to change their behavior. Defendants, however, continue to deny any wrongdoing. Consequently, there is a threat that defendants will continue to violate the antitrust laws. The third element, balancing the hardships, (referred to by Glassman among others at trial) has been analyzed separately according to each type of injunctive relief requested.

Plaintiffs suffered two forms of antitrust injury as a result of defendants' violation of the antitrust laws, paying supra-competitive prices and Compcare's exclusion from the HMO market. Plaintiffs request equitable relief to restore competitive pricing for medical services in the relevant markets to ensure against future supra competitive prices. Plaintiffs also request equitable relief to allow Compcare to enter the HMO services market by guaranteeing access to Marshfield physicians to form an HMO and request that Marshfield be divested of its subsidiary, Security.

Plaintiffs request the divestiture of the Lakeland and Flabeau Clinics from the Marshfield Clinic. A court may order divestiture as part of injunctive relief in an

action between private parties in suits under section 16. *California v. American Stores Co.*, 495 U.S. 271, 295 (1990). However this does not mean that such power should be exercised in every situation in which the Government would be entitled to relief under section 15. Plaintiffs in their Trial Brief in Support of Injunctive Relief did not cite to a single case in which *retroactive* divestiture was awarded in a *private* section 1 or 2 case. The only case cited was *International Travel Arrangers v. NWA, Inc.* 723 F. Supp. 141 (D. Minn. 1990), *aff'd.*, 991 F.2d 1389 (8th Cir.), *cert. denied*, 114 S.Ct. 345 (1993) which stated in dicta that divestiture is available in private sections 1 and 2 suits. Divestiture has been awarded in section 7 cases in the context of proposed mergers and in cases brought by the government. "Potentially disruptive remedies such as divestiture of completed transactions involving integration of ongoing business activities have never been granted in private suits under section 7." *Glendora v. Gannette*, 858 F.Supp. 369, 372 (S.D.N.Y. 1994) *aff'd.* 40 F.3d 1238 (2nd Cir. 1994). Indeed the Seventh Circuit upheld the district court's refusal to order defendants to divest the Bulls franchise as an equitable remedy for their illegal conduct in *Fishman v. Estate of Wirtz*, 807 F.2d 520 (7th Cir. 1986).

It is questionable whether divestiture of a long completed transaction is an appropriate remedy in a private action under the Sherman Act. In any event it is not an appropriate remedy here. Divestiture of the Lakeland and Flambeau clinics would require Marshfield to sell its ownership interest in the former Lakeland Medical Center (which includes sale of physician practices in Minoqua/ Woodruf, Park Falls, Phillips and Mercer) and in the Flambeau Medical Center Hospital. Less drastic remedies are available which are designed to halt anti-competitive conduct and agreements. Moreover the balance of equities does not favor divestiture. The Marshfield Clinic came into these areas at the request of local providers who

requested Marshfield to preserve and expand the access to care. (Tr. at 1282-1290.) Divestiture would have a large impact on third parties such as patients, Marshfield doctors and others that have not been before this Court to protect their interests.

The next category of relief requested is to void and prohibit all contracts, combinations and conspiracies in restraint of trade. A court should enjoin the precise practices found to have violated the Act. *United States v. Grinnell Co.*, 384 U.S. 563, 579 (1966); *see U.S. v. Crescent Amusement Co.*, 323 U.S. 173, 188 (1944) ("Civil suits under the Sherman Act would indeed be idle gestures if the injunction did not run against the continuance or resumption of the unlawful practice.) Injunctive relief should be fashioned to prevent the recurrence of the illegality which brought on the given litigation. *United States v. Loew's, Inc.*, 371 U.S. 38, 52 (1962). To ensure that relief is effectual, otherwise permissible practices connected with the acts found to be illegal must sometimes be enjoined. *Id.*, at 53.

Plaintiff request that Marshfield and Security be enjoined from entering into or enforcing certain agreements with the Gunderson Clinic, Rice Clinic, Wausau area physicians, the North Central Health Protection Plan, and Rhinelander Medical Center concerning (1) administrative services, (2) administration of health plans, (3) allocation of customers, territories, product or service markets, (4) setting of fees or prices, (5) free flow agreements, and (6) marketing. These types of agreements have the effect of reducing competition. Prohibiting them is an appropriate remedy for a monopolist guilty of past anti-competitive conduct to reduce the threat that such anti-competitive conduct will continue. If defendants are involved in the supervision of a competitor where they have access to information that can help them reduce competition they can influence that provider to reduce competition. Thus supervision of competitors will be en-

joined, but providing purely administrative services will not. If defendants are involved in the administration of the health plans of their competitors, they can reduce competition. Allocation of customers, territories, products or service markets are acts which are per se illegal as is price fixing. Defendants involvement with its competitors' marketing can also limit competition but such limitation is not found to be necessary here.

For example, The Gunderson Clinic, located in La-Crosse, consists of 270-300 doctors, is one of the 5 largest medical group practices in Wisconsin and competes with Marshfield. There was reasonable evidence in the record from which the jury could find defendants conspired to monopolize by controlling the Gunderson Clinic. Marshfield has a contract to provide certain administrative services for Gunderson. (Tr. at 1094.)

The Rice Clinic, located in Stevens Point, is also one of defendants' competitors. There was reasonable evidence from which a jury could find that Marshfield conspired with the Rice Clinic to monopolize physician services. Marshfield engaged in negotiations to acquire Rice. (Tr. at 1092-1093.) Marshfield now has a management services contract with Rice. Marshfield serves as manager and where Rice requires administrative services it must ask Marshfield to provide it first. (Tr. at 1092.) This is the same type of agreement Marshfield had with Lakeland before Marshfield acquired it.

There was also sufficient evidence from which a jury could find that Marshfield and Wausau area physicians conspired to monopolize physician services. Marshfield and Wausau agreed not to enter competing agreements with other HMOs for their Security 65 HMO. (Tr. at 1361-1363.) Marshfield also attempted to purchase/affiliate with Wausau Medical Center. (Tr. at 1315-1316.) The North Central Health Protection Plan is an HMO operating with Wausau area physicians. There is evidence from which a jury could find that Marshfield

and Security divided territory with NCHPP in violation of section 1. NCHPP can only be sold in certain areas and Security in others. The two plans market separately. (Tr. at 856-857.) The Rhinelander Medical Center uses NCHPP in Lincoln County only and uses Security in Oneida County only. (Tr. at 865-866, 870-871.)

Rhinelander Medical Center near Lakeland competes with Marshfield. (Tr. at 862.) It has about 30 doctors all of whom are either Marshfield doctors or affiliated with Security. (Tr. at 712-713.) There is evidence in the record from which a jury could find that Marshfield allocated territory with Rhinelander. (Tr. at 865-868, 870-871.) Marshfield warned Rhinelander about signing with more than one HMO. Rhinelander then cancelled NCHPP in Oneida county in favor of a relationship with Security. (Tr. at 712-713.) Rhinelander participates in NCHPP in Lincoln County and participates in Security in Oneida County only. (Tr. 865-866, 870-871.)

Defendants object to this relief on numerous grounds. They claim this would void beneficial agreements. While these agreements have some beneficial attributes, they tend to reduce competition. A monopolist found guilty of illegally conspiring with competitors to reduce competition simply should not be involved in the supervision of its competitors. Nor should a monopolist engage in a free flow agreement with a competitor because it reduces the chances that the competitors will expand into each other's markets. Fee setting and market allocation speak for themselves. The risks of anti-competitive conduct outweigh the limited benefits the agreements may provide. Defendants express concern that they will no longer be able to provide certain physician services that are needed in other areas. Nothing in this order prevents Marshfield from providing physician services for competitors.

Next, plaintiffs request that defendants be enjoined from entering into or enforcing any agreement which pro-

hibits Marshfield physicians from providing cross-coverage. The jury was instructed that it could find liability only if it found barriers to entry in the relevant markets. The inability to obtain cross-coverage was considered to be a barrier to entry for independent physicians attempting to practice in the rural areas of the relevant markets. Contrary to customary rural practice Marshfield's policy was to refuse cross-coverage to independent physicians. (Tr. at 553, 588, 489, 500.) Marshfield in fact denied such cross-coverage. (Tr. 501, 526, 463, 353, 397, 480.) While defendants complain about the problems of insurance when providing cross-coverage for non-Marshfield physicians, any problem posed by liability coverage is outweighed by the need to lift barriers to entry for independent physicians in order to open the Marshfield market to competition.

Plaintiffs request that defendants be enjoined from entering into or enforcing any non-compete or other exclusivity agreements which restrain the ability of physicians employed by Marshfield to practice in any location after terminating employment with the Marshfield Clinic. Marshfield employed doctors are currently required to sign non-compete contracts. (Tr. at 711.) Defendants assert that these agreements are required to protect their investment in recruiting and training physicians. Normally these agreements, if reasonable, are enforceable but when utilized by an illegal monopolist they are not justified. Prohibiting these agreements could help to open the relevant markets to competition. Defendants have asserted in opposing divestiture that many Marshfield doctors would leave the area without the support of Marshfield. If this is valid, defendants have no concerns because even in the absence of such restrictive covenants, Marshfield doctors will not leave.

Plaintiffs further request that any agreements requiring referrals of patients by any physicians or other providers to the Marshfield Clinic or its physicians be prohibited.

This practice created the illegal monopoly in specialty physician services and should cease. However, any agreements which require as part of the Security HMO that Marshfield physicians and physicians who are part of the Securtiy HMO network refer Security HMO patients only to physicians that are part of the Security HMO are valid. Using a distinct panel of doctors is the very essence of an HMO. The practice is only anti-competitive when patients who are not a part of the security HMO are referred exclusively to Marshfield Clinic. There is no justification for such an anti-competitive policy as requested by plaintiffs.

Next plaintiffs request an injunction prohibiting defendants for a period of five years from entering into any agreement or understanding to acquire, administer or control any presently existing independent physician, physician group, clinic or hospital, HMO except Security, or managed care network. Providing this relief as to the Gunderson Clinic, Rice Medical Center, Wausau Medical Center, and NCHPP should prevent defendants from expanding their monopoly and from further reducing competition by taking over competitors. There is a great risk that Marshfield will engage in such activity in the future because it has systematically taken over physician practices in the past. There is also evidence that it has attempted to control or acquire these clinics. (Tr. at 1094, 1092-1093, 1315-1316.) Any potential harm from this restriction is outweighed by the danger posed by Marshfield expanding its monopoly and forcing other potential competitors from the market. This does not prevent Marshfield from starting a new practice or entering competitive markets, so there is no danger that this injunction would harm an under-served area.

Next plaintiffs request an injunction prohibiting defendants from comprising more than 30 percent of the number of physicians of any committee intended to review, recommend, approve or restrict privileges at any hospital or participating in any peer review process at any

hospital. This request is harsh and its purpose may be accomplished by other means. Its purpose is to remove a barrier to independent physicians attempting to enter the market. The barrier is the inability of independent physicians to obtain approval for staff privileges at various hospitals where the credentialing committees were dominated by Marshfield doctors. There was evidence that Marshfield physicians restricted hospital privileges of competitors. (Tr. at 358-363, 399-401.) The injunctive relief which prohibits Marshfield from adopting any practice which limits hospital privileges of qualified doctors not employed by Marshfield is sufficient to accomplish this purpose.

Plaintiffs request an injunction to prevent defendants from entering into any agreement, adopting any practice or attending any meeting with the Ministry Corporation or its representatives concerning (1) joint marketing; (2) ownership, control, administration or operation of any health care facility; (3) plan for regional development health care; (4) recruitment; (5) allocation of territories, customers, products or services; (6) setting fees or prices and (7) service to be provided by Ministry Corporation Hospital to or for any health care insurer. Ministry corporation is involved in operating hospitals in the Marshfield area. Ministry and Marshfield have marketed certain specialty care items together and have engaged in joint planning where Ministry purchases certain equipment and Marshfield recruits the personnel to use it. Ministry and Marshfield are competitors for certain items such as outpatient surgery. There was evidence in the record from which a jury could find that Marshfield and the Ministry corporation allocated territory for outpatient care, emergency, or urgent care. (Tr. at 927-929.) Defendants have pointed to certain benefits such as cost savings that outweigh the potential risks to competition. However, in those areas in which they are competitors, they are enjoined from allocating territories, customers, products or

services and from setting fees or prices. These activities are always illegal between competitors.

Defendants will be enjoined from entering into any agreement which affiliates any physician with Security Health Plan based in whole or part on whether such physician is employed by Marshfield or Rhinelander Medical Center. This will open competition and give independent physicians willing to be paid at the Security rate a chance to have more patients. This should not harm defendants because they are not ordered to affiliate with all interested physicians.

Plaintiffs also request an injunction prohibiting Marshfield from entering into any agreement which restricts the location at which a physician affiliated with Security Health Plan may provide services for which Security Health Plan will allow reimbursement. An HMO cannot have an unlimited number of affiliated physicians in different geographic areas. Having some reasonable limits on the number of physicians in an area allows an HMO to be cost effective. Limitations on where an affiliated physician may practice and receive reimbursement for HMO patients does not preclude that physician from seeing non-Security patients in other areas.

Finally, plaintiffs ask the Court to set price levels for defendants' services. Plaintiffs allege that this will force defendants to finally sell at a competitive price. This Court refuses to micro-manage the health care economy in North-Central Wisconsin and has provided reasonable injunctive relief. This relief is intended to open the market to competition and is crafted to allow the market to self-adjust to competitive pricing.

ORDER

IT IS ORDERED that defendants' motion for judgment as a matter of law pursuant to Rule 50 of the Federal Rules of Civil Procedure, is GRANTED as to

Question 4 of the Special Verdict and DENIED in all other respects.

IT IS FURTHER ORDERED that defendants' alternative motion for new trial on liability pursuant to Rule 59 of the Federal Rules of Civil Procedure is DENIED.

IT IS FURTHER ORDERED that defendants' motion for a new trial on damages is GRANTED unless the aforesaid remittitur is accepted by the plaintiffs as set forth herein.

IT IS FURTHER ORDERED that any acceptance of remittitur by the plaintiffs shall be trebled by the Court and amended judgment to include costs, reasonable attorneys fees and expenses shall be entered together with that injunctive relief which follows:

I. JURISDICTION

This Court has jurisdiction over the parties and subject matter. Jurisdiction is retained by this Court for the term of this Order to enable any of the parties to this Order to apply to this Court at any time for the construction or implementation of the Order, for the enforcement or modification of any of its provisions and for sanctions for any violation thereof.

II. DEFINITIONS

A. "Agreement" shall be broadly construed to include all agreements, understandings and contracts, whether written, oral or otherwise.

B. "Central and north central area" shall mean the following counties: Adams, Ashland, Barron, Bayfield, Buffalo, Burnett, Chippewa, Clark, Douglas, Dunn, Eau Claire, Florence, Forest, Iron, Jackson, Juneau, La Crosse, Langlade, Lincoln, Marathon, Monroe, Oneida, Pepin, Pierce, Polk, Portage, Price, Rusk, St. Croix, Sawyer, Shawano, Taylor, Trempelau, Vilas, Washburn, Waupaca, Waushara and Wood.

III. APPLICABILITY

This final Order applies to each defendant and to each of the defendants' officers, board members, administrators, agents, servants, representatives, employees, successors, and assigns.

IV. VOID CERTAIN AGREEMENTS

Defendants Marshfield Clinic and Security Health Plan are enjoined and restrained from directly or indirectly entering into or enforcing any of the following Agreements, understandings and other described actions and a Declaration is hereby made that such Agreements, understandings and described actions are void and of no effect, as follows:

A. Any agreements or understandings with the Gunderson Clinic concerning:

1. Supervision;
2. Administration of health plans;
3. Allocation of customers, territories, product or service markets;
4. Setting of fees or prices;
5. Free flow of health plan patients.

B. Any Agreements or understandings with the Rice Clinic concerning:

1. Supervision;
2. Administration of health plans;
3. Allocation of customers, territories, product or service markets;
4. Setting of fees or prices;
5. Free flow of health plan patients.

C. Any Agreements or understandings with Wausau area physicians concerning:

1. Supervision;
2. Administration of health plans;
3. Allocation of customers, territories, product or service markets;
4. Setting of fees or prices;
5. Free flow of health plan patients.

D. Any Agreements or understandings with North Central Health Protection Plan concerning:

1. Supervision;
2. Administration of health plans;
3. Allocation of customers, territories, product or service markets;
4. Setting of fees or prices; and
5. Free flow of health plan patients.

E. Any Agreements or understandings with Rhinelander Medical Center concerning:

1. Administration of health plans;
2. Allocation of customers, territories, product or service markets;
3. Setting of fees or prices;
4. Free flow of health plan patients.

F. Any Agreements or understandings which directly or indirectly limit, prohibit or tend to limit or prohibit Marshfield physicians from providing cross-coverage to non-Marshfield physicians.

G. Any Non-Compete or other Exclusivity Agreements or understandings which directly or indirectly prohibit or restrain the ability of a Marshfield employed physician from practicing in any location after terminating employment with the Marshfield Clinic.

H. Any Agreements or understandings requiring referrals of patients by any physicians or other provider to the Marshfield Clinic or its physicians except for Security HMO patients.

V. PROHIBITED CONDUCT

Marshfield Clinic and Security Health Plan are enjoined and restrained for a period of three (3) years from the following:

A. Entering into any Agreement or understanding to directly or indirectly acquire, supervise or control the Gunderson Clinic, the Rice Clinic, the Wausau area physicians and NCHPP.

B. Entering into any Agreement, having any policy, adopting any practice or procedure or providing an incentive of any type or kind which directly or indirectly may tend to in any way limit or prohibit cross-coverage of any physician not employed by the Marshfield Clinic;

C. Entering into any Agreement, having any policy, adopting any practice or procedure or providing an incentive of any type or kind which directly or indirectly may tend to prohibit or limit hospital privileges of any qualified physician not employed by Marshfield Clinic;

D. Entering into any Agreement, having any policy, adopting any practice or procedure or attending any meeting with the Ministry Corporation or its representatives concerning:

1. Allocation of territories, customers, products or services;

2. Setting of fees or prices.

E. Entering into any Agreement, having any policy, adopting any practice or procedure or providing an incentive of any kind which directly or indirectly affiliates any physician with the Security Health Plan based in

whole or in part on whether such physician is employed by the Marshfield Clinic or Rhinelander Medical Center.

VI. EQUAL ACCESS

A. The defendants Marshfield Clinic and Security are enjoined from discriminating against Blue Cross/Compcare in providing them access to its physicians, products and services for the purposes of establishing an HMO in the Greater Marshfield and Northcare areas.

B. The defendants Marshfield Clinic and Security are enjoined from charging supra-competitive prices for their services and products.

VII. COMPLIANCE PROGRAM

Marshfield Clinic and Security Health Plan shall maintain an antitrust compliance program which shall include:

A. Distributing within thirty (30) days from the entry of this Order, a copy of this Order to all their respective officers, directors, trustees, administrators and employees.

B. Notifying the Marshfield Clinic and Security Health Plan officers, directors, trustees, administrators, employees, and affiliated physicians within thirty (30) days from the entry of this Order that they are not bound by any agreement described herein as void.

C. Distributing in a timely manner a copy of this Order to any successor corporation or person who succeeds to a position as officer, director, trustee, administrator, employee or affiliated physician.

D. Holding a briefing annually for all operating officers, directors, and administrators concerning the meaning and requirements of this Order.

E. Obtaining from each operating officer and administrator an annual, signed written certification pursuant to 28 U.S.C. § 1746 that he or she has: (1) read, understands and agrees to abide by this Order; (2) has been advised and understands that noncompliance with this

Order may result in sanctions; and (3) is not aware of any violation of this Order.

F. Maintaining for inspection by plaintiffs a record of recipients to whom this Order has been distributed and from whom the certification required by Paragraph VII. E. has been obtained; and

G. Conducting an audit of its activities within sixty (60) days from the entry of this Order and annually thereafter to determine compliance with this Order.

VIII. CERTIFICATIONS

A. Within thirty (30) days after the entry of this Order, each defendant shall certify to plaintiffs and the Court whether it has made the distribution of this Order and made the necessary notifications in accordance with Paragraph VII A. and VII B. herein.

B. For three (3) years after the entry of this Order, on or before its anniversary date, each defendant shall certify annually to plaintiffs whether defendants have complied with the provisions of Paragraph VII., Sections C, D, E, F and G.

IX. NOTICE AND PUBLICATION

Marshfield Clinic and Security Health Plan shall provide by first class mail, postage pre-paid, a copy of this Order to the following persons within thirty (30) days of the entry of this Order:

A. All physicians practicing in the central and north central Wisconsin area;

B. All hospitals located within the central and north central Wisconsin area;

C. All Security Health Plan affiliated physicians;

D. Rhinelander Medical Center;

E. Gunderson Clinic;

F. North Central Health Protection Plan;

G. Wausau Clinic;

H. Rice Clinic; and

I. Rice Lake Clinic.

X. EXPIRATION OF ORDER

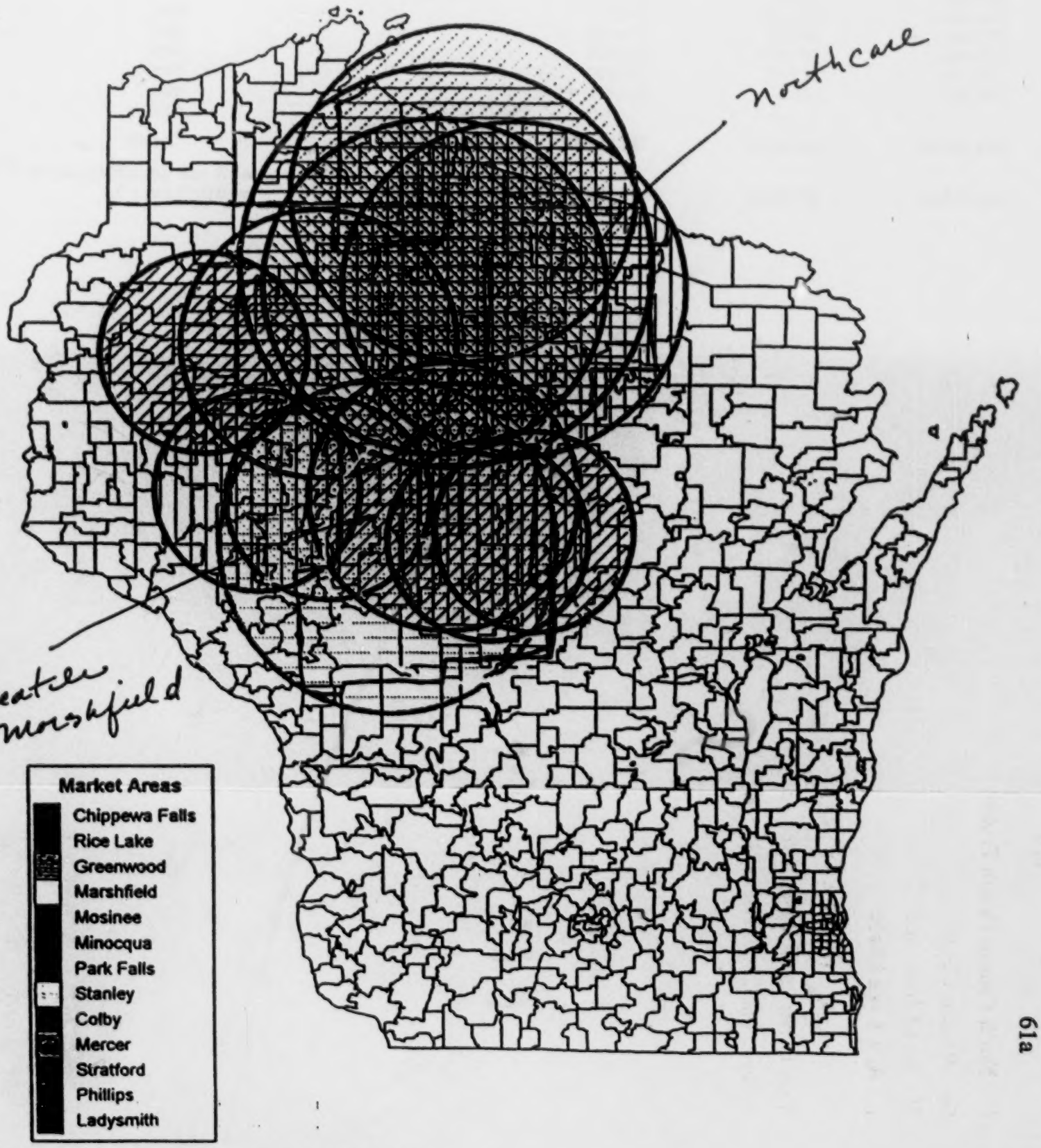
This Order shall expire three years from this date.

Entered this 22nd day of March, 1995.

BY THE COURT:

/s/ John C. Shabaz
JOHN C. SHABAZ
District Judge

Dr. Greenberg's Primary Care Markets



Source: Report of Warren Greenberg, Exhibit 6

Summary of Damages Incurred by Blue Cross and Compcare

	Damages Due to Higher Physician Fees (Based on Indemnity Payments Only)	Damages Due to Foreclosure into GMHP Area	Damages Due to Foreclosure into Northcare Area	Total Damages
	(dollars)			
1988	$ 69,092	—	—	$ 69,092
1989	179,726	—	—	179,726
1990	113,462	(150,000)	—	(36,538)
1991	89,766	127,500	(25,500)	191,766
1992	85,557	617,571	(15,431)	687,697
1993	57,280	367,570	80,875	505,725
1994	—	719,268	(93,812)	625,456
1995	—	459,272	21,300	480,572
1996	—	506,159	(16,507)	489,652
1997	—	304,475	13,116	317,591
1998	—	176,166	6,324	182,490
1999	—	—	—	
Total	$594,883	$3,127,981	($29,635)	$3,693,229
Total—Reducing the Effect of Cost-Shifting	$594,883	$4,920,299	$135,978	$5,651,160

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT
CHICAGO, ILLINOIS 60604

October 13, 1995

Before

Hon. Richard A. Posner, Chief Judge

Hon. William J. Bauer, Circuit Judge

Hon. Michael S. Kanne, Circuit Judge

Nos. 95-1965, 95-2140

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN
and COMPCARE HEALTH SERVICES
INSURANCE CORPORATION,
Plaintiffs-Appellees,
Cross-Appellants,

v.

MARSHFIELD CLINIC and
SECURITY HEALTH PLAN OF WISCONSIN, INC.,
Defendants-Appellants,
Cross-Appellees.

Appeals from the United States District Court
for the Western District of Wisconsin

No. 94 C 137S—John C. Shabaz, *Judge*

ORDER

Upon consideration of the petition for rehearing and the brief of the United States and the Federal Trade Commission in support of the petition, the slip opinion in this matter, issued on September 18, is amended as follows:

P. 3, after first full sentence, beginning "These contracts are not exclusive . . .": the following sentence is inserted: "(Compcare argues that the 6 percent figure is found only in a study and testimony excluded from evidence, but our reading of the objection to the testimony and the ruling on that objection is that not the figure, but only the witness's effort to characterize it as insignificant, was excluded.)"

P. 6, after last full sentence on page, ending "a separate market.": the following sentence is inserted: "(We emphasize "record compiled in the district court." Terms such as "HMO" and "PPO" are used to refer to a variety of different types of plan, which may vary in respects crucial to antitrust liability.)"

P. 9, first sentence after paragraph break: "because HMOs are not a market" is changed to "because, subject to our earlier qualification, HMOs are not a market".

P. 16, before paragraph break: at end of preceding paragraph (ending "1338") the following new sentence is inserted: "Perhaps, as the Department of Justice believes, these clauses are misused to anticompetitive ends in some cases; but there is no evidence of that in this case."

Save for these amendments to the slip opinion, the petition for rehearing is DENIED.

APPENDIX D

IN THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

Nos. 95-1965, 95-2140

BLUE CROSS AND BLUE SHIELD UNITED OF WISCONSIN and COMPCARE HEALTH SERVICES INSURANCE CORPORATION,
Plaintiffs-Appellees,
Cross-Appellants,

v.

MARSHFIELD CLINIC and SECURITY HEALTH PLAN OF WISCONSIN, INC.,
Defendants-Appellants,
Cross-Appellees.

On Appeal from the United States District Court
for the Western District of Wisconsin

BRIEF FOR THE UNITED STATES AND THE FEDERAL TRADE COMMISSION AS AMICI CURIAE IN SUPPORT OF PETITION FOR REHEARING

INTEREST OF THE UNITED STATES AND THE FEDERAL TRADE COMMISSION

The United States and the Federal Trade Commission are principally responsible for enforcing the federal antitrust laws and have been active in the health care area.

In the last 18 months, the Department of Justice and the Commission have filed over 20 antitrust health care cases, have jointly issued the "Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust," and have issued numerous business reviews and advisory opinions to health care providers. Currently, the Department and the Commission are conducting over 80 health care investigations. Thus, the United States and the Commission have a strong interest in the clear articulation and proper application of antitrust principles in this area.

STATEMENT

Plaintiff Blue Cross/Blue Shield is a health insurer; its subsidiary, Compcare, is a Health Maintenance Organization (HMO). Defendant, Marshfield Clinic is a physician-owned clinic; it owns Security, an HMO.

Blue Cross filed suit against Marshfield, alleging violations of sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2, and related state law violations. Blue Cross claimed that Marshfield had monopolized the HMO market and injured Blue Cross (as a potential competitor in that market through Compcare) by refusing to allow Marshfield doctors to deal with HMOs competing with Security, thus denying access to an "essential facility." In addition, Blue Cross claimed that Marshfield's monopolization of various health care markets and its related anticompetitive agreements with other health care providers resulted in supracompetitive prices for medical services, which injured Blue Cross as a purchaser of such services for its subscribers.

The jury found in favor of plaintiffs on all of a series of special verdicts and found damages of over $15 million. Defendants moved for judgment as a matter of law and for a new trial. The district court upheld the jury verdicts on liability, but granted a new trial (subject to a remittitur) on damages. It also entered an injunction, which this Court stayed pending appeal.

This Court reversed. It held that the record could not support a finding that HMOs constitute a relevant market, and thus that Security could not be liable for monopolizing HMO services. It also concluded that Marshfield does not have a monopoly share of physician services because it does not control the independent physicians who provide services under contractual arrangements with Marshfield and Security, and that monopoly power could not be inferred from Marshfield's prices.

With respect to the section 1 claim, the Court held that no collusion between Marshfield and its affiliated (non-employee) physicians had been proved because the only evidence of "collusion" was that Marshfield "would not pay them more than what these physicians charge their other patients," and this "is not price fixing." Slip op. at 15-16. The Court, however, found the evidence of market division "a little scanty, [but] sufficient to sustain the jury's verdict." *Id.* at 17. It remanded for revision of the injunction in accordance with its opinion and a new trial limited to damages for market division. *Id.* at 17-19.

DISCUSSION

The United States and the Federal Trade Commission take no position on the sufficiency of the record to support the jury's verdict. We are concerned, however, that the Court's explanations of its conclusions on two issues may mislead readers unfamiliar with the record and arguments in this case as to the law applicable to market definition and analysis of "most-favored-nation" ("MFN") agreements—issues that frequently arise in health-care antitrust cases.

1. *Market Definition.* As this Court has recognized, market definition is a factual question. Slip op. at 3; *see also Brown Shoe Co. v. United States*, 370 U.S. 294, 326 (1962); *United States v. Rockford Memorial Corp.*, 898 F.2d 1278, 1283-85 (7th Cir.), *cert. denied*, 498 U.S. 920 (1990); *Fishman v. Estate of Wirtz*, 807 F.2d 520,

531 (7th Cir. 1986). Accordingly, this Court's holding that the record in this case contains no evidence to support the jury's finding that HMOs comprise a separate market from other forms of health care delivery should not preclude a finding on a different record of a relevant product market limited to HMOs. *See U.S. Healthcare v. Healthsource, Inc.*, 986 F.2d 589, 598-99 (1st Cir. 1993) (recognizing that HMOs could be a separate market from other forms of health care financing, but concluding that plaintiffs had not so proved).

We are concerned, however, that the Court's statement that "HMOs are not a market" (slip op. at 9) might be read inappropriately out of context, to establish a rule of general applicability. Such a misinterpretation would be extremely unfortunate, for market definition in a health care antitrust case requires careful attention to the facts. Terms such as "HMO" or "PPO" can refer to a range of health care plans that vary widely in price, quality, features, and the extent to which they compete with one another. Health care markets are evolving rapidly, as providers and purchasers search for more efficient delivery systems. Thus, it is of critical importance that lower courts avoid any temptation to substitute reliance on generalizations or assumptions about the functioning of health care markets for careful analysis of the evidence presented in a particular case. In particular, we are concerned that the Court's observation that "the price that an HMO can charge is constrained not only by competition from other HMOs but also by competition from [other] forms of medical services contracting," (slip op. at 5) could be misinterpreted as a holding that any competition between two health care products necessarily forecloses the possibility that they are separate markets. As this Circuit has recognized, the products included in a relevant antitrust market "may not exhaust the alternatives open to [consumers]." *Rockford*, 898 F.2d at 1284. The question is the extent to which customers are likely to shift to various alternatives if prices for a particular product

rise above a competitive level, *id.* at 1285. *See also U.S. Healthcare,* 986 F.2d at 599 (the issue in determining whether HMOs constitute a separate market is "whether a sole supplier of HMO services . . . could raise price far enough over cost, and for a long enough period, to enjoy monopoly profits").

Indeed, while broader markets might be relevant for some purposes, that does not preclude recognition of an HMO market in appropriate circumstances. For example, the evidence in a particular case might establish that some current HMO customers so strongly prefer HMOs that they would not switch to other delivery systems even if price were raised to a noncompetitive level. If those customers were sufficiently numerous that the HMOs could profitably raise prices despite the loss of other customers (who did not so strongly prefer HMOs) to competing delivery systems, HMOs could collectively exercise market power. Thus, while it may generally be true that at least some customers will regard some PPOs as acceptable substitutes for some HMOs, only a fact-specific analysis on a particular record can establish whether the challenged practices threaten to harm consumers in a relevant market.[1]

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[1] Similarly, in assessing the likelihood that providers of HMO services could exercise market power, it would not be appropriate for a court merely to assume that physicians will readily "shift from one type of service to another if a change in relative prices makes one type more lucrative than others" (slip op. 6). While some physicians who provide (or would be willing to provide) services through a PPO might join particular new HMOs if existing HMOs raised prices above a competitive level, other doctors might prefer not to assume the financial risks associated with HMO participation or might be unwilling to accept HMO-imposed constraints on their practice of medicine. Whether the possibility of physicians shifting among service delivery arrangements would significantly constrain the ability of HMOs to raise price is a factual question to be resolved on the record in individual cases.

The Court could avoid the risk of serious misinterpretation by modifying the opinion to emphasize that its conclusion that "Security is not a monopolist of HMO services because HMOs are not a market" (slip op. at 9) and its observations relating to the ability of HMOs to exercise market power were based on the record in this case and were not intended to foreclose the possibility of a different result on a different record. In particular, the Court should make clear that it did not reject the jury's finding of an HMO product market simply because HMOs face some competition, regardless of the likelihood that such competition will provide an effective constraint on the ability of HMOs to exercise market power.

2. *Most-Favored Nation Clauses.* As the Court observed, MFN clauses may serve legitimate purposes in particular circumstances, and we do not dispute the Court's conclusion that the record in this case does not establish per se illegal price-fixing. *See* slip op. at 16. We are concerned, however, that the Court's discussion may be misinterpreted as a holding that such clauses never violate the Sherman Act.

MFN clauses may raise serious concerns under the antitrust laws.[2] For example, among other situations, a court might be faced with evidence that a party with a significant degree of market power used an MFN clause to restrain competition or evidence that competing providers were using such clauses as a means of reducing competition. MFN clauses might cause providers to refuse to discount their fees to anyone, when the result of selective discounts would be a reduction in fees from a plan that provides a significant portion of their income.

[2] We do not read the First Circuit's decision in *Ocean State Physicians Health Plan v. Blue Cross*, 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990), as establishing a rule of per se legality for that Circuit. It, too, addressed only the facts of a particular case.

They might also impede competition among plans by making it very difficult for new plans to obtain viable panels of providers. Indeed, the United States has challenged MFN clauses in agreements between major health care plans and participating health care providers as unreasonable restraints of trade in three recent cases. The consent decrees negotiated in these cases prohibit the defendants from entering into or enforcing such agreements. *United States v. Delta Dental Plan of Arizona, Inc.*, 1995-1 Trade Cas. (CCH) ¶ 71,048 (D. Ariz. 1995), *see* 59 Fed. Reg. 47349 (Sept. 15, 1994); *United States v. Oregon Dental Service*, 1995-2 Trade Cas. ¶ 71,062 (N.D. Cal. 1995), *see* 60 Fed. Reg. 21218 (May 1, 1995); *United States v. Vision Service Plan*, No. 1:49CV02693 (D.D.C. complaint and proposed consent decree filed Dec. 15, 1994), *see* 60 Fed. Reg. 5210 (Jan. 26, 1995).

This case does not require the Court to anticipate the circumstances under which an MFN might be held to violate the Sherman Act. We are concerned, however, that the Court's description of MFN clauses as "standard devices by which buyers try to bargain for low prices" and "the sort of conduct that the antitrust laws seek to encourage" (slip op. at 16) may be misunderstood as a conclusion that they necessarily pass muster under the Sherman Act or that an intent "to minimize the cost" (*id.*) of physicians' services is necessarily determinative.[8] We urge the Court, therefore, to make clear that its ruling related to the particular clause in the particular circumstances at issue in this case and that other cases involving MFN clauses must be evaluated upon their own facts.

CONCLUSION

The United States and the Federal Trade Commission take no position on the ultimate question of the suffi-

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[8] *Compare U.S. Healthcare*, 986 F.2d at 596 (motive is important to the extent that it serves as "a guide to expected effects, but effects are still the central concern of the antitrust laws").

ciency of the evidence in this case. We urge the Court to grant rehearing, however, so that the panel may modify its opinion to leave no doubt (1) that whether HMOs constitute a separate market is a question of fact and that the Court's conclusions with respect to the sufficiency of the evidence in this case would not foreclose findings in other cases that HMOs constitute a relevant antitrust market, and (2) that its conclusion as to the MFN clauses in this case does not foreclose a different result on a different record.

Respectfully submitted.

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October 2, 1995

APPENDIX E

[Filed Jan. 3, 1995]

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

94-C-137-S

BLUE CROSS & BLUE SHIELD
UNITED OF WISCONSIN and
COMPCARE HEALTH SERVICES
INSURANCE CORPORATION,
Plaintiffs,

v.

THE MARSHFIELD CLINIC and
SECURITY HEALTH PLAN OF
WISCONSIN, INC.,
Defendants.

SPECIAL VERDICT

1. Have the plaintiffs established one or more of the following relevant product and geographical markets?

a) HMO Services?

ANSWER: Yes
(Yes or No)

b) Primary Care?

ANSWER: Yes
(Yes or No)

c) Pediatric Care?

ANSWER: Yes
(Yes or No)

d) One or More Specialty Care Markets?

ANSWER: Yes
(Yes or No)

IF YOU ANSWERED YES TO QUESTION 1, PROCEED TO QUESTION 2. OTHERWISE PROCEED TO QUESTION 6.

2. Do the defendants possess monopoly power in any relevant market you found to exist?

ANSWER: Yes
(Yes or No)

IF YOU ANSWERED YES TO QUESTION 2, PROCEED TO QUESTION 3. OTHERWISE PROCEED TO QUESTION 4.

3. Have the defendants engaged in anti-competitive conduct to obtain or maintain monopoly power in any relevant market in which defendants have monopoly power?

ANSWER: Yes
(Yes or No)

4. Have defendants attempted to monopolize in any relevant market in which they do not possess monopoly power?

ANSWER: Yes
(Yes or No)

5. Have defendants conspired to intentionally obtain or maintain monopoly power in any relevant market?

ANSWER: Yes
(Yes or No)

6. Have defendants entered into a contract, combination or conspiracy the purpose of which or predictable effect was to unreasonably restrain trade in any relevant market?

ANSWER: Yes
(Yes or No)

7. Have defendants contracted, combined or conspired with a competitor or potential competitor to do any of the following in any relevant market?
(Answer yes or no)

a) Allocate customers?	Yes
b) Allocate territories?	Yes
c) Allocate product or service markets?	Yes
d) Fix fees or prices	Yes

IF YOU ANSWERED YES TO ANY PART OF QUESTION 7, ANSWER QUESTION 8 AS TO THAT PART OF NUMBER 7 TO WHICH YOU ANSWERED YES, OTHERWISE PROCEED TO QUESTION 9.

8. Was the purpose or predictable effect to unreasonably restrain trade?

(Answer yes or no)

a) Allocate customers?	Yes
b) Allocate territories?	Yes
c) Allocate product or service markets?	Yes
d) Fix fees or prices	Yes

9. Did defendants violate section 133.04 of the Wisconsin Statutes?

ANSWER: Yes
(Yes or No)

Signed this 30th day of December, 1994.

/s/ James Byrnes
Foreperson

APPENDIX F

Section 1 of the Sherman Act, 15 U.S.C. § 1, provides:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding $10,000,000 if a corporation, or, if any other person, $350,000, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

Section 2 of the Sherman Act, 15 U.S.C. § 2, provides:

> Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding $10,000,000 if a corporation, or, if any other person, $350,000, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.